



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Arkansas**

**Application for 2009  
Annual Report for 2007**



Document Generation Date: Thursday, September 25, 2008

# Table of Contents

I. General Requirements .....	4
A. Letter of Transmittal.....	4
B. Face Sheet .....	4
C. Assurances and Certifications.....	4
D. Table of Contents .....	4
E. Public Input.....	4
II. Needs Assessment.....	5
C. Needs Assessment Summary .....	5
III. State Overview .....	6
A. Overview.....	6
B. Agency Capacity.....	11
C. Organizational Structure.....	21
D. Other MCH Capacity .....	24
E. State Agency Coordination.....	28
F. Health Systems Capacity Indicators .....	32
Health Systems Capacity Indicator 01: .....	32
Health Systems Capacity Indicator 02: .....	33
Health Systems Capacity Indicator 03: .....	35
Health Systems Capacity Indicator 04: .....	36
Health Systems Capacity Indicator 07A: .....	38
Health Systems Capacity Indicator 07B: .....	39
Health Systems Capacity Indicator 08: .....	40
Health Systems Capacity Indicator 05A: .....	40
Health Systems Capacity Indicator 05B: .....	42
Health Systems Capacity Indicator 05C: .....	43
Health Systems Capacity Indicator 05D: .....	44
Health Systems Capacity Indicator 06A: .....	45
Health Systems Capacity Indicator 06B: .....	46
Health Systems Capacity Indicator 06C: .....	46
Health Systems Capacity Indicator 09A: .....	47
Health Systems Capacity Indicator 09B: .....	49
IV. Priorities, Performance and Program Activities .....	50
A. Background and Overview .....	50
B. State Priorities .....	52
C. National Performance Measures.....	57
Performance Measure 01: .....	57
Performance Measure 02: .....	59
Performance Measure 03: .....	61
Performance Measure 04: .....	63
Performance Measure 05: .....	64
Performance Measure 06: .....	66
Performance Measure 07: .....	68
Performance Measure 08: .....	70
Performance Measure 09: .....	73
Performance Measure 10: .....	75
Performance Measure 11: .....	77
Performance Measure 12: .....	80
Performance Measure 13: .....	82
Performance Measure 14: .....	84
Performance Measure 15: .....	86
Performance Measure 16: .....	87
Performance Measure 17: .....	89
Performance Measure 18: .....	91

D. State Performance Measures.....	94
State Performance Measure 1: .....	94
State Performance Measure 2: .....	95
State Performance Measure 3: .....	97
State Performance Measure 4: .....	99
State Performance Measure 5: .....	102
State Performance Measure 6: .....	103
State Performance Measure 7: .....	105
State Performance Measure 8: .....	107
State Performance Measure 9: .....	109
State Performance Measure 10: .....	111
E. Health Status Indicators .....	113
F. Other Program Activities .....	115
G. Technical Assistance .....	117
V. Budget Narrative .....	119
A. Expenditures.....	119
B. Budget .....	121
VI. Reporting Forms-General Information .....	124
VII. Performance and Outcome Measure Detail Sheets .....	124
VIII. Glossary .....	124
IX. Technical Note .....	124
X. Appendices and State Supporting documents.....	124
A. Needs Assessment.....	124
B. All Reporting Forms.....	124
C. Organizational Charts and All Other State Supporting Documents .....	124
D. Annual Report Data.....	124

## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. Assurances and Certifications**

All assurances and certifications are kept on file in the Center for Health Advancement, located in the Arkansas Department of Health in Little Rock.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

In accordance with the Guidance for the 2009 Title V Maternal and Child Health Block Grant Application, the first of two public hearings was held Friday, July 11, 2008 at the Arkansas Department of Health. A notice was placed in the Arkansas Democrat Gazette-Northwest and the Arkansas Democrat Gazette-Little Rock for seven consecutive days starting, Friday, June 6 and ending on Thursday, June 12. Seven (7) people (all of whom were Department of Health or Department of Human Services staff) attended, with Dr. Richard Nugent conducting the hearing. He opened the floor for comments, but none was offered.

Although there were no public comments during the public hearing, we will continue to welcome comments from the parent/advisory group for CSHCN, as well as other groups with input regarding the served population. after the MCH Block Grant Review in August, at which time copies of this document will be shared and discussed.

## II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

//2008// The needs assessment conducted this year consisted of a review of all measures tracked for the MCH Block Grant, and a presentation to the Center for Health Advancement and to State Health Officer, Dr. Paul Halverson. Comments on the progress of the MCH effort were entertained.//2008//

***//2009// The needs assessment was conducted this year in the same fashion as last year.//2009***

***//2009//*** Arkansas has begun its process of needs assessment development in preparation for the application to be submitted in July of 2009 for the FY 2010. Early this year, the Family Health Branch coordinated a strategic planning conversation with all other Branches in the Center for Health Advancement. These include Chronic Disease, Oral Health, Tobacco Prevention and Cessation, WIC, and a cross-cutting Branch called Life Stages. A preliminary discussion of priorities that are of interest to all the Center's Branches was held. A subsequent priorities development conversation will be held with the ADH Executive Team, following which a similar strategic discussion will be held with other Departments in state government, as well as UAMS, the ADH Regions, and the ADH Hometown Health Leaders. The last phase of this planned process is a repeat of that followed for the 5-year needs assessment at the beginning of this cycle. ***//2009//***

### III. State Overview

#### A. Overview

##### 1. The broader health delivery system

The entire Arkansas state population, about 2.7 million people, resides in a region of 75 counties. The city of Little Rock, the state's largest, is situated approximately in the middle of the state, and is the site for 6 large hospitals, the University of Arkansas for Medical Sciences (the medical school), the Department of Health and Human Services (Arkansas Department of Health as of 7/2007), and other state agencies relating to the health of children. Cities of moderate size are located in the corners of the state, including Fayetteville and Fort Smith in the northwest, Jonesboro in the northeast, Hot Springs in the midwest, Texarkana in the southwest, El Dorado in the midsouth, and Pine Bluff in the Delta Region of the Mississippi River. These cities provide the population base for sizable medical communities and are the locations of Area Health Education Centers (AHECs). Over the state as a whole, the number of physician practices is probably adequate to provide the necessary medical services, but in certain underserved areas, physician and other health provider shortages are common. UAMS, based in Little Rock, provides a centralized point of referral for all medically complicated patients, and also provides medical and health education for the entire state. Except for the communities of West Memphis and perhaps Helena on the eastern border of the state who depend on the city of Memphis in Tennessee, all state communities relate to UAMS and Little Rock Hospitals as the major source of highly specialized medical care. The AHECs provide Family Medicine residency training in communities around the state, and have been of great assistance in improving the distribution of primary care physicians to the corners of the state. By far the most numerous specialty in Arkansas, Family Physicians provide most of the state's medical care. Specialists in obstetrics, pediatrics, internal medicine, surgery and others have practices in the more urban communities. While Arkansas is geographically of modest size compared to some other states, the distances from cities such as Fayetteville and Texarkana to Little Rock require two and one-half to four hours of travel time. For families with few resources, these distances represent significant barriers in access to highly specialized care.

##### 2. The system of state agencies providing support to the health system for women and children

The Arkansas General Assembly in its 2005 session passed legislation formally merging the Department of Health and the Department of Human Services into a new Department of Health and Human Services.

//2008// The Arkansas General Assembly, in its 2007 session, passed legislation allowing the Governor to "de-merge" the Department of Health and Human Services into its Department of Health and Department of Human Services components. As of July 1, 2007, the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services (DHS) are again separate, cabinet-level agencies. A new table of organization is attached. Much of the description of the previous organizational structure presented in earlier versions of this Title V application has been removed in the interests of brevity and clarity. //2008//

***//2009// The new structure of the ADH has now become well established. Leadership in all the newly reworked administrative offices has been hired and is gaining experience. Dr. Halverson has recently conducted a subsequent strategic planning process. Guided by a nationally experienced facilitator, the ADH Executive Team and Senior Staff, including Dr. Joseph Thompson, the Arkansas Surgeon General, developed a Strategic Map. A copy of that map is attached. The Overall Goal of the ADH is To Improve Health and Reduce Disparities. Under that goal there are five Priority Areas:***

***- Strengthen Core Services -- (Family Planning, Prenatal Care, Immunizations, WIC, Home Health, etc) by quality assessment, recommendations for improvement, implementation of***

*those recommendations and re-evaluation.*

*- Develop more Effective Population-Based Approaches -- (Injury prevention and control, Reduce infant mortality, Increase physical activity, and Improve Oral Health).*

*- Communicate Public Health Value and Societal Contribution -- (Economic development, Public awareness, Benefits of prevention).*

*- Secure Adequate Human and Financial Resources -- (Workforce needs, Workforce training, gaps, funding acquisition).*

*- Increase Departmental Effectiveness and Accountability -- (Strengthen leadership, management systems, IT infrastructure, data utilization, accountability).*

*Cross-cutting all these areas are emphases on community engagement, partnerships, and policy development. //2009//*

*//2009// The overall theme is to strengthen and improve traditional public health clinical services; and, at the same time, focus on several specific program developments, engage more in public awareness and policy developments, and retool administrative processes to work more effectively and efficiently.//2009//*

*//2008// The CSHCN Program, in the structure after July 1, 2007, will remain in the Division of Developmental Disabilities Services now located in the Department of Human Services (DHS). //2008//*

*//2008// The ADH (beyond July 1, 2007) prioritizes health services according to the strategic planning process already established by State Health Officer, Dr. Paul Halverson, including internal and external phases. 1) ADH continues to provide the highest priority services in all counties. Highest priority services include Immunization, Family Planning, WIC, STI, infectious disease outbreak management, Breast and Cervical Cancer Control, and environmental health. In the past, well child clinics fell into this category, but with Medicaid assignment of EPSDT children to primary care physicians in the private sector, these clinics were discontinued by the Department of Health. Other highest priority services have traditionally been provided not in the local clinics, but through the Central Office. These include Newborn Metabolic and Hearing screening, and collaborations with Medicaid to assure enrollment in Medicaid and appointments with primary care physicians. These highest priorities continue. 2) Second priority services include basic preventive services for which availability is necessary in all counties, but for which local health systems may not have sufficient capacity. These include maternity care, and home health services. 3) The remaining priorities include those preventive services that are optional for counties such as services for patients with diabetes and hypertension. //2008//*

*//2008//Over the past several years, the Department of Health has been developing request for proposal programs to fund competitive special projects in selected counties. Services provided through these resources included Abstinence Education, Unwed Birth Prevention, and Smoking Cessation.//2008//*

*//2008// The state of Arkansas will now manage the Title V program in the two separate Departments. The Maternal and Child Health services will now be managed in the Arkansas Department of Health (ADH), and the Children with Special Health Care Needs services are managed in the Department of Human Services (DHS). That arrangement provides the administrative context for maternity and preventive children's services to be conducted in Local Health Unit clinics throughout the state, and for Children with Special Health Care Needs services to be managed in close relationship with the DHS Divisions of Developmental Disabilities, Children and Family Services, and Medicaid. CSHCN services are closely associated with specialty services of the Department of Pediatrics at UAMS. //2008//*

*//2008// Many remarkable earlier changes in these services had occurred in Arkansas, preceeding the 2005 merger and 2007 de-merger of the two state agencies. For example, the Medicaid Program reorganized the EPSDT Program to create the AR Kids First Program.*

Medicaid assigned all EPSDT enrolled children to primary care physicians (largely private doctors) and ADH discontinued providing EPSDT screenings. At the same time, the new AR Kids First Program raised income eligibility for children of low-income families to 200% of poverty. The federal State Child Health Insurance Program (SCHIP) funds enabled an increase in eligibility from 185% (133% or 100% depending on age) to 200% of poverty for children up to 18. As a result the number of children in low-income families who were not covered declined. With a reduction in need, and without reimbursement, the ADH discontinued its well child clinics. ADH still provides services for children including immunization, injury prevention, newborn metabolic screening, newborn hearing screening and other prevention programs for children including SIDS. ADH uses the 30% of MCH Block Grant funds required to support health services for children to enhance immunization programs and maintain preventive and population-based services for children. Especially, ADH uses some of the 30% funding for children's health systems to enhance its collaborative efforts with DHS Divisions and the Department of Education (DOE) for such initiatives as Early Childhood Education, Coordinated School Health, and the System of Care for Child Mental Health.//2008//

//2008//Dr. Paul Halverson will remain as the Director of the ADH, and Dr. Joseph Thompson will remain as the chief medical advisor to the Governor (now called the state's "Surgeon General"). Both are cabinet positions and are active in the deliberations of the Board of Health, though the Surgeon General does not have a vote, and the Director may not serve as chair. The 2007 General Assembly also provided that the duties and responsibilities of the State Board of Health be brought to the ADH largely intact. The leadership of ADH will retain the structure of its Executive Staff, and the Centers, including Local Public Health, Health Advancement, Health Protection, Health Practice, and the State Laboratory. Externally, links to communities remain strengthened through continuation of the Hometown Health Initiative staff in ADH. //2008//

//2008// Mr. John Selig will remain as Director of Human Services, and his commitment to interagency cooperation continues. //2008//

//2008// Links between health-related organizations in state government and the University of Arkansas for Medical Science are remarkably stronger with the development of the College of Public Health. Links with the professional boards of Medicine, Nursing, and other disciplines remain strong. The new Department of Health will continue with its responsibilities to license hospitals in the state, and to relate closely with the Hospital Association. Other disciplines such as dentistry, pharmacy and chiropractic continue their representation on the Board of Health, along with medicine, nursing and hospitals.//2008//

//2008// As presented above, environmental services and clinical services that are preventive in nature and represent "gap-filling" activities will continue in the 94 local health units in 75 counties. Local services are supported by a system of Franchise Agreements (FAs). FAs set out the requirements for service delivery conducted in communities as led by five Regional Teams. In addition to Franchise Agreements, the ADH makes special grants to local community lead agencies for special program interventions. These local projects include tobacco control, chronic disease, oral health, family planning outreach, and services to the developmentally disabled. However, a great deal of programmatic support is provided to regional leadership and technical assistance through the School Cooperatives that house the Community Health Nurse Specialists (CHNS) and the Community Health Program Specialists (CHPS). These offices link the program resources of tobacco control, chronic disease, and maternal and child health to assist schools.//2008

Arkansas's population stood at 2.7 million people as of 2004. Among states, Arkansas has high proportions of rural, low income and minority citizens. A very broad range of health measures in this state rank unfavorably compared to other states. These include many of the data trends captured in the MCH Block Grant performance measures. Arkansas' five health regions are diverse in geography and demography. The Central Region around Little Rock is relatively urban and well supplied with available health services for women and children. However, even in these

counties low-income families experience barriers in access to care. All other regions are rural and poor and many are medically underserved as defined by HRSA programs. Counties along the eastern border of Arkansas, the Mississippi Delta are especially rural and poor and have high concentrations of minority populations, especially African American. Counties along the western border are mountainous and rural. They have fewer minorities, but are high impact for immigrant Hispanic families from Central and South America. A group of Marshallese families live in the far northwestern counties and experience outbreaks of several infectious diseases. Counties along the southern border of the state are also rural and poor, depending on farming and timber as their predominant source of income.

//2008// As the task of "de-merging" the Department of Human Services (DHS) and the Department of Health (ADH) proceeds, any impact on Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) programs will become evident, but we do not anticipate a great deal of change. The transfer of the Title V CSHCN program within DHS from the Division of Medical Services (DMS-the division that includes the state's Medicaid program) to the Division of Developmental Disabilities Services (DDS) has been successful. In DDS, the Title V CSHCN program has found a mutual family friendly "spirit". //2008//

//2008// While the DDS Children's Services reorganization continues, the CSHCN program will need to be an articulate advocate for maintaining and even developing both reimbursement programs for special needs children and important enabling services such as care coordination and transitional care. //2008//

//2007// As of June, 2006, internal reorganization of the Division of Health has made much progress. Dr. Halverson, as Director, is aided by Dr. Joseph Bates, the Deputy Director for Science, Mr. Charles McGrew, MPH as the newly appointed Deputy Director and Chief Operating Officer, and Mr. Michael Wolff as Deputy Director, who brings a wealth of administrative experience from private sector health organizations. Mr. Randy Lee, RN, has been appointed as Director of the Center for Local Public Health, and Mr. Stephen Boedigheimer, MBA remains as CDC Senior Management Official, our liaison officer to CDC. Mr. Boedigheimer's chief responsibility is to manage the "CDC Portfolio of programs" conducted by the Arkansas Division of Health. Newly directed by Dr. Jennifer Dillaha, the Center for Health Advancement now houses the Family Health Branch (managing the MCH Block Grant), as well as Branches for Chronic Disease, WIC, Oral Health, and Life Stages. The Life Stages Branch is "cross-cutting." It houses offices for Children in Schools, Adults in the Workplace, and the Elderly in Communities. It also houses experts in Nutrition, Physical Activity, and Tobacco Cessation. //2007//

//2007// The four recently established Centers within the Division are taking form. In the Center for Local Public Health, now directed by Mr. Lee, Mr. Rick Sanders serves as Associate Director for Management and Operations, Mr. Lee's former role. Dr. Richard Nugent serves as Associate Director for Science, Ms. Aurian Zoldessy as State Patient Care Director, Bill Rodgers as Rural Health and Primary Care Director, and Neldia Preston as State Quality Improvement Leader. The Offices of the five Health Regions are managed in this Center, as are the Branch Offices of Environmental Health, Field Support Services, and In-Home Services (Home Health). //2007//

//2007// The Center for Health Protection is directed by Mr. Donnie Smith, and Dr. William Mason serves as Associate Director for Science. Mr. Ron Stark serves as Associate Director for Management and Operations. That Center's Branches include Health Systems Licensing and Regulation, Infectious Disease, Preparedness and Emergency Response, and Injury Prevention and Control. //2007//

//2007// The Center for Public Health Practice is Directed by Martha Phillips, PhD, MPH, MBA, an epidemiologist, Ms. Michelle Priebe as Associate Director for Management and Operations, and Dr. Frank Wilson as Associate Director for Science. The Branches in that Center include Health Statistics, Epidemiology, Workforce and Career Development, and Health Marketing. //2007//

//2007// The fifth Center is the State Laboratory, Directed by Dr. Glen Baker. Mr. Ed Just serves as Associate Director for Management and Operations. The Center's Branches include Clinical, Biological, Chemical, and Alcohol Testing. //2007//

//2007// The Center for Health Advancement (CHA), in which the MCH Program is administered, is Directed by Dr. Jennifer Dillaha. Ms. Maria Jones serves as the Associate Director for Management and Operations, Dr. Namvar Zohoori as Associate Director for Science, Ms. Jane Costello as Director for Quality Improvement, and Ms. Marilyn Dunavant as Grants Manager. The Branches of the CHA include Chronic Disease, Family Health, Lifestage/Healthy Arkansas, Nutrition and WIC, Oral Health, and Tobacco Prevention and Cessation. //2007//

//2008// As a Department, ADH will continue to develop the Centers as described above, and will develop its own offices for finance, personnel, information technology, mail room, and other administrative functions. Transitional plans for these changes are in effect (beginning May, 2007) and the offices should be functioning by the fall. The structure of the Centers within the health organization are not anticipated to change, except for the addition of the administrative offices. //2008//

//2008// Ms. Kaki Roberts has been hired as the Budget Coordinator for the Center for Health Advancement. //2008//

//2007// The Family Health Branch is headed by Dr. Richard Nugent as Chief, and Ms. Carladder Paham as Associate Chief. It houses the MCH-related Sections of Child and Adolescent Health, Women's Health, and Connect Care. The Connect Care Section is funded largely by a contract from Medicaid, and is the office providing coordinated outreach and education to Medicaid Recipients, assignment to primary care physicians, and assignment to dentists. A major role of this Section is to operate a 24/7 telephone hotline center serving Medicaid, Healthy Arkansas, the Healthier Babies Campaign, and now the implementation of Arkansas's new Clean Air Act. //2007//

//2008// The ConnectCare Section was re-named "Health Connections" to better reflect the diversity of responsibilities in the Section. The activities encompassed in the Medicaid contract continue to use the moniker "ConnectCare." //2008//

//2008// Ms. Carladder Parham was promoted to Director for the Central Health Region, and left her position as Associate Chief of Family Health last year. Mr. Bradley Planey was promoted to Associate Chief of Family Health in May, 2007. Mr. Planey formerly served as the Chief of the Women's Health Section within the Branch, and a replacement will be recruited. Ms. Berna Thomas, hired as a grants manager to assist with both the MCH Block Grant and the Title X Grant, has accepted another job in the agency. Her position has been reassigned to the new administrative offices of the ADH in transition. Ms. Li Zheng, the MCH Epidemiologist, resigned and her position has been refilled by Terri Wooten. Terri is a long-time statistician in the Center for Health Statistics, and has been responsible for developing the MCH Block Grant Annual Report for many applications. She is near completion of her MPH Degree in Epidemiology, and already brings great familiarity not only with MCH data, but also MCH programs and planned data analysis for policy development. A new table of organization for the Center and Branch is appended. //2008//

//2008// In the National and State Performance Measures the state health agency is referred to consistently as the Arkansas Department of Health or ADH, whether referring to past, current or future activities. //2008//

***An attachment is included in this section.***

## **B. Agency Capacity**

***//2009// The Arkansas Department of Health 's organizational structure is functioning well since being restored as a stand-alone agency in state government on July 1, 2007. A recent strategic mapping discussion at the Executive and Senior Staff level confirms the Department's commitments to maintaining and improving its clinic services in local health units, and its renewed commitments to public awareness and policy development for many health issues.//2009//***

//2008// The new Arkansas Department of Health (ADH) will continue to address the health of women and children. July 1, 2007 was its official start date. This health agency returns to its former name and maintains many of the internal organizational relationships begun under Dr. Halverson in the past 2 years. Besides developing administrative offices for finance, personnel, IT and support services, little change at the Center level and above is anticipated. //2008//

Arkansas has a variety of state statutes that guide the provision of services to mothers and children. There is no overall statutory authority for the MCH population, so existing statutes will be discussed within each of the subpopulations.

### **1. Preventive and Primary Services for Infants and Pregnant Women**

Maternity Medical Services works to ensure all pregnant women in Arkansas have access to early and continuous prenatal care, thereby reducing the number of preterm and low birth weight infants and lowering infant mortality and maternal morbidity and mortality.

#### **Target Population**

Pregnant women in Arkansas, specifically those with no other source of prenatal care.

#### **Description of Services**

Maternity clinics provide prenatal services, including risk assessments, laboratory, physical assessments, patient counseling, prenatal education classes, nutrition, social work counseling and referrals for high-risk care. Case management and follow-up ensures patients receive services needed. Medicaid eligibility is determined and, where possible, patients are referred to local physicians for continuance of care. All Local Health Units offer basic pregnancy testing and counseling, and referral to local physicians or to a neighboring Unit giving prenatal care. Working with the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS, ADH anticipates implementing new screening methods for smoking, depression, partner violence and substance abuse. State law requires that all pregnant women be tested for HIV, unless they have been counseled and have refused the test.

//2008//All local health units provide pregnancy testing, prenatal counseling, and screening for presumptive Medicaid eligibility. The county health units work with nearby Local Health Units, and other care providers to ensure pregnant women have access to early prenatal care. Clients are provided referral information and accessibility to other ADH services, such as WIC and Immunizations. In 64 sites, located in 57 counties, ADH also provides prenatal clinic care that includes physical assessments, laboratory testing, genetic screening and counseling, prenatal education, nutritional counseling and education, WIC services, and referrals as indicated for high risk care. ADH clinicians and public health nurses work closely with the University of Arkansas's perinatal program, ANGELS (Antenatal and Neonatal Education Guidelines, Education and Learning System). With significant support from the Arkansas Department of Health and Human Services, ANGELS provides evidence-based guidelines for maternal-fetal and neonatal care. //2008//

//2007// The Licensing Program for Lay Midwives promulgates regulations, monitors the practice of Midwives and their Apprentices, sponsors and staffs the Midwife Advisory Board, pursues disciplinary action, and provides in-service education. There are now 31 Licensed Lay Midwives

and 9 Lay Midwife Apprentices. In 2004, 216 women began care with a lay midwife, with 157 of those women continuing in midwifery care through delivery. State law provides for the maintenance of a licensure program for midwives, and the Board of Health writes regulations in support of that statute.

//2008// The Midwifery Licensure program, with IADH legal support and major input from licensees, has majorly rewritten midwifery regulations. Those regulatory changes were adopted in the spring of 2007. We are now preparing an educational program, to be transmitted via the Internet, to train the 32 licensed midwives. New forms for reporting both births attended, and apprentices trained, are being developed, and will also be forwarded as required for administrative review by the state legislature. //2008//

**//2009// Recent regulatory change brought approval of new forms operationalizing the new midwifery rules. //2009//**

Support for the Campaign for Healthier Babies is both monetary and in-kind. In-kind support aids responses to requests for coupon books and other information. Monetary assistance helps with planning the Campaign's activities and provider relations efforts.

In addition, the ADH manages a home health program called In Home Services. Part of the care it provides is called the Maternal and Infant Program (MIP). MIP, if requested by a local health unit and ordered by Dr. Nugent, will make home visits to pregnant women at risk. For example, one at-risk group includes pregnant adolescents who would benefit from home assessment and further follow-up. In addition, MIP will visit pregnant women who have medical complications such as pre-eclampsia requiring bedrest, diabetes requiring insulin therapy, or infants requiring special monitors or IV therapy.

## 2. Primary and Preventive Services for Children

The purpose of the Child and Adolescent Health Program is to encourage community-driven public health by promoting safer and healthier communities through education, prevention, and intervention by ensuring that statistically driven initiatives are in place through integrated stewardship.

### Target Population

Birth through adults for the State of Arkansas.

### Description of Services

Child and Adolescent Health comprises different programs serving the needs of the communities in Arkansas such as Community Smoke Alarm Installation and Education Program, Fire & Fall Prevention of Adults, Core Injury, Violence Prevention/Intervention, Infant Hearing, and Childhood Injury Prevention.

//2007// The Injury Prevention Services Program was moved to the Center for Health Protection. Funding for infant car seats and the Safe Kids Coordinator position was discontinued with the ending of the Preventive Health Services Block Grant. The following services were transferred to Health Protection from Child and Adolescent Health:

- Installation of smoke alarms in five hundred households per county;
- Training for senior citizens in fire and fall prevention;
- Establishment of coalitions and focus groups for core injury and violence prevention;
- Collaboration with Hometown Health Improvement Coordinators to identify areas that will benefit from the violence programs;
- Curriculum for various programs listed above. //2007//

The Arkansas Safe Kids Coalition distributes free bicycle helmets to community groups, school

groups, health fairs, and bicycle rodeos and provides preventive measures and education for children and caregivers on the importance of using seat belts.

//2007// Child and Adolescent Health continues to provide the following services:

//2007// State statutes provide the legal basis for infant hearing screening, newborn metabolic screening and hospital licensure (containing hospital standards for services to women and children). 1) The hearing statute establishes that all hospitals delivering over 50 babies a year will conduct physiologic hearing screening on newborns, and will report the results to the ADH. 2) The Laws regarding newborn metabolic screening require birthing hospitals to obtain heel-stick blood specimens from babies, and to submit them to the State Lab. 3) State statutes provide for the licensing and review of hospitals within the state. For each of these laws, the Board of Health has established regulations that are monitored and revised from time to time as needed for the system of care they each guide. In the 2005 legislative session, a change in the newborn screening law established that the Department would conduct, in addition to the nationally "mandated" newborn screens of PKU, Hypothyroid disease, Galactosemia and Sickle Cell disease, "other tests" as provided for in regulation from the Board of Health. This change provided the legal basis for the Board of Health to require the implementation of expanded newborn screening as recommended by the National Foundation, March of Dimes. //2007//

//2008// The Board of Health has initiated regulatory change to extend newborn metabolic screening to cover the 29 "Core" conditions recommended nationally for all states to implement. The rule change process is now being pursued and should be completed by the winter of 2007. With the Governor's support, and with the passage of the state budget in the 2007 session of the General Assembly, Arkansas provided positions and appropriation to recruit new staff for the Lab and the Follow-up programs. On July 1, 2007, ADH started recruiting for the extended staff for the Laboratory and the Follow-up Programs. ADH anticipates that a full year of program development will be needed to hire and train staff, obtain special laboratory equipment, run a pilot study of Arkansas children to set "cut points" for lab readings, develop follow-up and referral protocols, and carry out professional education and public awareness efforts. //2008//

**//2009// On July 1, 2008, the ADH initiated expanded NBS screening covering all 29 nationally recommended conditions. //2009//**

The Abstinence Education Program awards subgrants to local communities to support abstinence education initiatives. Some grants are funded by the MCH Bureau, through the ADH. Those grants require match of three non-federal dollars for every four federal dollars awarded. Match requirements are achieved with in-kind donations from local communities. Each sub grantee is required to maintain records of clients served, develop a quarterly narrative progress report and track and monitor program activities. In previous years, the sub grantees were required to work with the state evaluator. The evaluation determines the program effectiveness by assessing student knowledge and behavior regarding sexual health values and practices. A Final Report is anticipated June 2008. Technical assistance workshops provide knowledge and training of grant requirements to sub grantees. Site visits (monitoring) are performed to assure the quality of the data collected and to view abstinence interventions in the local communities.

//2008// Federal funding for the Abstinence Education Program through Title V and other sources, as of this writing (June, 2007) is being heavily questioned because of a relatively rigorous Mathematica evaluation in a number of communities of differing demographics, showing no change in behavior despite adequate "dosage" of instruction and contact. In fact, communications from the funding federal agency prohibit incurring any costs against the Title V program after June 30, 2007. Planned renewals of competitive community grants is on hold until future funding is assured. Early July Congress approved funding through September 30th, but the President has yet to sign the bill. //2008//

**//2009// The assuredness of funding for Abstinence Education continued to decline and the**

***number of funded projects also declined.//2009//***

**Target Population**

The Abstinence Education Program supports abstinence education for youth and young adults, ages 12 to 29.

Grants foster abstinence education (educational or motivational) programs that (1) have as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity; (2) teach abstinence from sexual activity outside marriage as the expected standard for all school-age children; (3) teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems; (4) teach that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity; (5) teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects; (6) teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society; (7) teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and (8) teach the importance of attaining self-sufficiency before engaging in sexual activity.

//2008// Currently, the Arkansas Abstinence Education community-based projects, now numbering 10, but having been active in 28 separate locations over the last 5 years, have been actively evaluated by Stan Weed, PhD, a behavioral researcher. At this time, a written interim report is available for review, and Dr. Weed has made a verbal report to the Department regarding his findings. The evaluation methodology includes assessing students by questionnaire before the start of the educational "dose," after the intervention has been carried out, and at 12 months after the close of the intervention. A review of the data from these questionnaires reveals improvements in values, beliefs and behaviors at the close of the intervention, but by twelve months after the close of intervention the effect is entirely gone.  
//2008//

The Office of Oral Health (OOH) envisions Arkansas as a state where everyone enjoys optimum oral health through primary prevention at the community, healthcare professional and family levels. This can be accomplished through: accessible, comprehensive and culturally-competent community-based oral health care provided through a variety of financing mechanisms; educational opportunities throughout life that will allow individuals to make better decisions for their health; and informed and compassionate policy decisions at all levels of government.

**Target Population**

Infants, children, adolescents, adults, and the elderly in the State of Arkansas.

**Description of Services**

OOH colleagues provide education and awareness on a variety of oral health issues including fluorides and fluoridation, dental sealants, infection control, oral cancer, access to care, tobacco cessation and prevention, and family violence prevention.

OOH assists communities with water fluoridation through community presentations and providing funding through the Preventive Health and Health Services Block Grant.

- Working with the Division of Engineering, OOH provides water plant operator trainings throughout the state.
- Working through the Arkansas Oral Health Coalition, OOH provides dental sealants to at-risk children.
- OOH colleagues conduct a wide variety of assessment activities throughout the state on children, adolescents and the elderly. Reports on the various assessment activities are available and are combined into an oral health burden document.

State legislative activity requiring fluoridation of public water supplies has occurred in Legislative session of 2003 and 2005 General Assembly.

### 3. Services for Children with Special Health Care Needs

//2007//Decrease in staff led to consolidating the caseload of CSHCN, whose specialty health care costs are born solely or in part by the Title V CSHCN program, among 3 RN's. There was no decrease in the number of qualifying applicants & open cases (approximately 600) so the caseloads increased substantially.//2007//

Current active cases include undocumented Hispanic children & youth that do not qualify for Medicaid because of their citizenship status. Since they are not eligible for SSI, the cost of their health care is born by the Title V CSHCN program. Approximately 40% of the applications received for children & youth are approved for payment of a diagnostic evaluation prior to any eligibility determination being made. Many of these individuals are subsequently found to be ineligible for ongoing coverage due to being financially ineligible or diagnostically ineligible. The RNs are able to make referrals for services the family may subsequently need & be quite unaware that the services are available or needed. As funding permits, Title V CSHCN works with families of eligible children & youth covered by Medicaid to fund purchases of equipment that is not covered in the Medicaid state plan (e.g. IPV machines, van lifts & wheelchair ramps) & payment for children & youth with special needs to attend various Med-Camps during the summer. Attendance at these camps allows time for peer interaction & socialization while teaching diagnosis-specific self-care in a fun camp environment. Title V CSHCN paid for services for approximately 100 children & youth covered by Medicaid for the purchase of equipment/services not covered by Medicaid.//2007//

//2008// Over the past year, Title V CSHCN has paid for equipment and services for 150 children & youth covered by Medicaid. This ranges from audiology visits, purchase of hearing aids, therapy & orthotics for children covered by the ARKids B program (SCHIP) to purchase of IPV machines for preemies to allow discharge home, wheelchair ramps, van lifts & overhead lifts for the home for children covered by SSI or TEFRA.//2008//

//2007// Title V staff provide Medicaid-reimbursed care coordination assistance to approximately 3,200 children & youth with special needs & their families. The Medicaid recipient must be medically eligible for the Title V CSHCN program unless the individual is under age 16 & receives SSI or TEFRA benefits. Those recipients receive Title V CSHCN care coordination assistance regardless of whether the diagnosis qualifies them medically for the program. The Title V CSHCN program cannot bill for care coordination assistance if any other program or provider is working with the family & billing Medicaid for care coordination. CSHCN staff consists of a Service Specialist, Social Worker or RN trained as a Title V CSHCN care coordinator & a medically trained Secretary who has received training & experience in care coordination. Knowledge of programs & providers of services in the state & local community allows Title V CSHCN staff to make appropriate referrals in a timely manner. Some referrals are for Special Needs Funds & Integrated Supports, DDS programs that provide timely relief to families with emergency needs. Title V CSHCN staff also make referrals & assist with applications for the ACS Home & Community Based Waiver. Approximately 3400 children & youth are served by Title V CSHCN staff for case management assistance.//2007//

//2008// Approximately 3900 children & youth receive care coordination services from Title V CSHCN staff.//2008//

**//2009// The AR Title V CSHCN program has continued to pay for services not covered by Medicaid. During the past year, 148 Medicaid recipients who qualify for coverage had services paid for by the Title V CSHCN program. The types of services paid for remain the same as previous years except for the purchase of IPV machines. The cost of those machines rose 40% within a few months. In response, the program implemented a new requirement regarding IPV machines. Since most requests come from Arkansas Children's**

***Hospital (ACH), the program required that the ACH Pulmonary Department utilize the existing process that enables providers to request Medicaid coverage of non-State Plan services by providing documentation of medical necessity to Arkansas Medicaid. Now most IPV machines are being paid appropriately by Medicaid as medically necessary and funds have been freed up in the Title V program for other needs.//2009//***

The Part C Early Intervention (EI) is managed by Title V CSHCN & oversees provision & coordination of services to over 3,000 infants & toddlers with a developmental disability or delay & to their families annually. Service coordinators assist families in accessing local services & in funding services. Regular contact is made with medical providers in local communities to assure that referrals are made as needed. This contact also assures that Title V CSHCN services are presented to the medical providers. Services are provided as a result of a multi-disciplinary team decision & service plan. Title V CSHCN staff serve as Service coordinators for Part C EI services with an average caseload of 148.

***//2009// Approximately 2,180 children and youth receive care coordination services from the Title V CSHCN staff. The decrease from the previous year is due to the removal of Part C Early Intervention job tasks from the majority of CSHCN staff responsibilities. In addition to this change, the program and staff have made a concerted effort to clean up the database by closing duplicate cases and initiating programming changes that created a system-generated process for closure of cases at age 22, if staff had not made the change.//2009//***

*//2007// 766 referrals were received by Title V CSHCN staff for Part C services during FY05.//2007//*

*//2008// 1,569 referrals for Part C services were received by Title V CSHCN staff during FY06. A decision has been made by the Division Assistant Director to pull Part C duties from the responsibilities of Title V CSHCN service coordinators & managers & form separate work units. There will be a subsequent shrinkage of service coordinators who are available to perform Title V CSHCN program tasks, but conversely, the removal of Part C referrals & requirements will increase the amount of time the remaining service coordinators have to perform the Title V CSHCN program tasks. //2008//*

***//2009// Four of the CSHCN staff were required to continue to work Part C cases until staffing in that unit was increased to assume the caseload. At the current time, two CSHCN staff (an RN and a SW) continue to work Part C cases--the SW on a full time basis and the RN works Part C in addition to providing CSHCN care coordination services.//2009//***

*//2007// Active cases in the Alternative Community Services Home & Community-based Waiver program were transferred from CSHCN staff to the Waiver Unit in the Division in May 2006. This allowed us to deploy those staff to serve CSHCN in a case management capacity once again.//2007//*

*//2008// Title V CSHCN care coordinators continue to work with families to access services through Developmental Disabilities Services (DDS) programs. The most prominent & time-consuming of these is the Alternative Community Services Home & Community Based Waiver. Other DDS programs include Integrated Supports services (for families in crisis situations who require wrap around services to enable them to keep their children & youth in the community) & Special Needs funding (a process to assist a family to obtain help in the form of respite, purchase of low cost equipment, receive training or assist with rent/utilities). //2008//*

***//2009// To provide accurate data to the work unit responsible for eligibility determination for the Alternative Community Services Home and Community Based Waiver (coordinated by the Division of Developmental Disabilities), a system was developed to allow the***

***program to monitor pending applications worked by CSHCN staff until they are determined eligible and placed on the service request list. Since beginning the process on February 19, 2008, the program has received 374 individual referrals. CSHCN staff currently manages 12 Integrated Supports cases on an ongoing basis. During the last state fiscal year, CSHCN staff processed 60 requests for DDS Special Needs funding.//2009//***

//2007// The Friends & Family Respite Waiver reapplications were withdrawn by the agency due to new requirements for all 1915C HCBA waivers. With the loss of those waivers, Title V CSHCN funded a respite program for those individuals who were served during the last year of the respite waivers. CSHCN staff refers other families for the assistance as they become known to them. Approximately 200 families have received financial assistance to fund respite services for qualifying children & youth.//2007//

//2008// the Title V CSHCN Respite program of 05-06 was completed with respite funding provided to 310 individuals between November 1, 2005 & October 31, 2006. Parental & employee input was obtained about the process for providing respite services during the next application period. The parents consulted felt that family needs vary & they should have the ability to choose how to spend the funds to help their CSHCN, with one of those options being respite. The program for the next year of service (11/1/06 -- 10/31/07) was changed & called the Title V Family Support/Respite Program. The program was funded for a max of 300 slots. Another recommendation from the parents was that the applications should be provided to all eligible people. That meant that over 19,000 applications were mailed out (to all SSI & TEFRA recipients in the state) for only 300 slots. Over 3,750 applications were received. Applications were reviewed on a 1st come 1st served basis with ratings done by a committee of 3 (includes a parent) with averaged scores & rated against a previously set eligibility point (taken from the previous Respite Waiver). The final slot was awarded in June 2007. Title V also paid for about 30 children/youth to attend summer med camps.//2008//

***//2009// The Title V Family Support/Respite Program for 11/1/06 -- 10/31/07 served 300 families of more than 3,750 applicants for the \$1,000 award. The agency cost in man-hours to process this number of applications was prohibitive considering the small number of awards made. A change was made in the process, effective 11/1/07. Each Regional Manager was given a fixed amount of funding to utilize for the families of CSHCN within their catchment area. Each of the care coordination staff would use the funding as a resource as they work with families of CSHCN. Applications are completed by the family. The care coordinator is required to make a home visit to meet with the family to discuss the application. The care coordinator rates the application based on a level of need established by prior year programs. The application is then routed to the Regional Manager for review, determination of eligibility and amount of award. To date, 233 applications have been received with 158 awards made. This year, the paperwork processing required for the issuing of payment was brought under CSHCN staff oversight which decreased the amount of processing time for payment. A total of 31 individuals had summer camp covered by the CSHCN program in addition to the individuals discussed earlier.//2009//***

Title V staff have provided services through the Medical Home Grant which ended March 31, 2005. A no added cost extension was granted. The extension will provide for the continuation of Project DOCC (Delivery of Chronic Care). This project has been coordinated by Rodney Farley of Title V CSHCN & has trained families that serve on the Title V CSHCN Parent Advisory Council to give an overview of the daily tasks that are involved in the lives of CSHCN. They invite Resident Physicians from the University of Arkansas Medical Sciences into their home for a glimpse into their lives & the changes that occurred with the CSHCN. The purpose of Project DOCC is to give physicians a better understanding of what CSHCN & their families go through on a daily basis & how their needs impact the entire family.

//2007// the no added cost extension for the Medical Home Grant expired in March 2006. Funding

for continuation of Project DOCC has been sought from various sources without success.//2007//

//2008// CSHCN staff have been actively involved in the Arkansas Early Childhood Education Comprehensive Systems (AECCS, also call CISS) grant. With the leadership in DHS of the Division of Child Care and Early Childhood Education (DCCECE), that collaborative project has advanced to the development and beginning implementation of a "five tiered" Quality Rating Scale for ECE providers. DCCECE is making funds available to incentivize ECEs to advance to higher quality levels.//2008//

***//2009// This year the Arkansas Early Childhood Education Comprehensive Systems grant has seen activity on multiple levels. Pilot studies were completed in both an urban and rural practice with good results noted in both practices. Currently development of a statewide spread strategy is a primary activity. The EPSDT incentives will be effective September 2008. Medicaid has also set in motion a method for reimbursement to physicians for developmental- and autism-specific screening, effect July 1, 2008. //2009//***

Through Title V CSHCN contact with families, a database of over 16,000 children & youth is maintained with whom we provide information via an annual newsletter. The newsletter is sent on a quarterly basis to families who have requested Title V CSHCN care management assistance, those who receive services paid for by Title V CSHCN funding & those whose ACS Home & Community Based Waiver case is coordinated by Title V CSHCN staff.

The Child & Adolescent Service System Program (CASSP): A statewide council made up of legislatively appointed membership from Human Services, Health & Education oversees CASSP. Membership also includes consumers, family members, mental health providers & advocacy groups. Fifteen Regional CASSP teams serve the children & youth around the state. Title V CSHCN staff are members of the regional teams & work as part of the team to assure that appropriate services are received.

//2008// The Title V CSHCN Program Administrator is now a member of the state level CASSP Coordinating Council. Title V CSHCN staff have been very active in working with local CASSP teams over the past year making referrals from one system to the other when working with dually diagnosed children & youth. The CASSP system should be incorporated into the System of Care Initiative that is currently on-going in Arkansas to address the mental & behavioral health needs & care system. The Division Director of DDS, Dr. Charlie Green, has been involved in this initiative from its' inception. System of Care planning has culminated in enabling legislation in the 2007 session of the Arkansas General Assembly. That new law provides the policy basis for developing a statewide system of care for mental health for kids. The State's First Lady is now concluding "Listening Sessions" in all parts of the state to initiate the implementation of this law.//2008//

***//2009// The CASSP program continues to function in its traditional way. The Behavioral Health System of Care program is moving forward in the development of plans to make the systems changes needed to address the concerns brought forward in 2007.//2009//***

Together We Can (TWC): DDS is the division responsible for the coordination of TWC. Title V CSHCN staff are members of the local team. TWC is a multi-agency, multi-departmental program that is available in 26 counties. It provides services to children who have multiple needs but unsuccessful services provided in the past. TWC services address intense emotional, interpersonal, or behavioral challenges, a lack of success in traditional services, the need for services from multiple agencies, and the desire to remain in the community.

***//2009// Plans to combine the Together We Can program with the CASSP program began in April 2008 to be effective July 1, 2008. By combining the programs there would be a presence in every county in the State of Arkansas with funding available to provide for needs that are not covered by other entities. //2009//***

Title V CSHCN staff provide leadership of Local Interagency Collaboration Councils (ICC). These teams are regional support for the State ICC that is the state's group monitoring the Early Intervention program. Membership in the local & state team includes DDS staff, Department of Education Early Childhood staff, providers & consumers.

//2007// Local ICC teams have been targeted by state CSHCN staff to improve participation. This has led to an increase in membership & activities statewide.//2007//

Title V CSHCN staff are members of Hometown Health Initiative (HHI) teams around Arkansas. The CSHCN staff is responsible for assuring that the needs of CSHCN are brought before the local teams.

Child Case Review Committee (CCRC) is an interagency team within DHS that brings staff from the Divisions of Children & Family Services (AR foster care agency), the Youth Services, Developmental Disabilities Services, Behavioral Health Services, Medical Services (Medicaid) & the DHS Director's Office to discuss problematic cases that cross divisional lines. The Title V CSHCN Assistant Director is a member of this committee.

The Title V CSHCN Program Administrator is a member of the Department of Health Oral Health Advisory Committee & Genetics Services Advisory Committee & these are explained in greater detail elsewhere in this application. The needs of CSHCN & their families are brought to the attention of these groups. Other committee members have given expert advice & referrals when problematic issues have arisen involving CSHCN.

The Title V CSHCN Unit Manager serves on the Medical Home committee for the Arkansas Early Childhood Comprehensive Systems (AECCS) grant with DHS Division of Child Care & Early Childhood Education.

By agreement with Arkansas Social Security Disabilities Determination Services office, information is forwarded to the Title V CSHCN program when they receive an application for SSI on any child or youth less than 16 years of age. Referrals are made for other services/programs for which the individual may also be eligible (e.g. Part C EI, DDS, Title V CSHCN & Mental Health). Approximately 2,000 such referrals were made during FFY 04.

#### 4. The WIC population

The mission of the Women, Infant and Children program (WIC) is to improve the health of infants, children and childbearing women by directly supplementing their diets with foods rich in nutrients they need, providing nutrition education and counseling and referrals to other services.

The mission of WIC Farmers' Market Nutrition Program is to encourage the consumption of fresh fruits and vegetables by WIC participants and encourage the development of farmers' markets.

##### Target Population

WIC: Pregnant, breastfeeding and postpartum women, infants and children under age five are eligible if they live in Arkansas, are income eligible and have a condition or living situation which places them nutritionally at risk. Income eligibility is based on 185% of the federal poverty guidelines.

FMNP: Women and children who are WIC participants in the counties with authorized farmers' markets are eligible.

##### Description of Services

Risk Assessment: A screening to determine nutritional status is performed on each applicant by a nurse, nutritionist, home economist, or physician.

Food: WIC participants receive nutritious, prescribed foods and purchase these foods as listed on WIC checks (bank drafts) at local grocery stores. FMNP participants receive coupons, not to exceed \$20, to purchase locally grown fruits and vegetables at farmers' markets.

#### Nutrition Education:

- Nutrition Counseling - Participants with potentially serious nutrition-related health problems are scheduled for individual counseling by nutritionists.

- Nutrition Education -- All participants or parents of participants are offered nutrition education including the selection and use of fresh fruits and vegetables in counties where FMNP is available.

- Breastfeeding Promotion and Support - All pregnant women are informed of the benefits of breastfeeding their infants. Breastfeeding women receive support services from trained health providers and may receive breast pumps.

Referrals to Other Services: WIC participants are referred to other services as needed by local clinic staff. Strong emphasis is given to childhood immunizations and prenatal care.

#### 5. Women and men of reproductive ages (Family Planning)

The purpose of the Reproductive Health Program is to provide reproductive health services to women and men, enabling them to choose the number and spacing of children and prevent unplanned pregnancies. Reproductive Health services include health history assessment, laboratory tests, physical assessment, contraceptive methods, health education, treatment and referral.

#### Target Population

Men and women of childbearing age in the State of Arkansas, primarily the low-income clients who are uninsured and under insured.

//2008// Women at high risk of unintended pregnancy will continue to be high priority populations for the Family Planning Program, to include: teens, minorities, low income women, women without insurance, and unmarried women.

Services offered to all clients include Health History Assessment, Laboratory Tests, Physical Assessment, Contraceptive Methods, Health Education, Treatment and Referrals. Clients are also strongly counseled on immunization needs. The Reproductive Health Program implemented health records specifically for male clients seeking reproductive services. These services are available to all Arkansas residents at ninety-two (92) Local Health Units (LHU) and one (1) contracted agency.//2008//

#### Description of Services

The Reproductive Health Program provides, through ADH and delegate agencies, clinic based family planning services to women in need of publicly supported services. Eighty percent of these women will be at or below 200% of poverty according to declared income and family size. In addition, the program provides outreach and education to hard to reach populations regarding family planning. This includes education on abstinence and male responsibility. The program also detects precancerous and cancerous changes of the uterine cervix through Cervical Cytology Screening.

The objective of unwed birth prevention efforts is to prevent pregnancies to unmarried teens throughout Arkansas. A variety of methods are utilized to include health education, outreach, and increased access to family planning services. During 2004 nine (9) County Coalitions targeted eleven (11) counties and reached eight thousand one hundred ninety-six (8,196) youth through

facilitation of "Programs That Work" curricula. An additional eight hundred twenty-seven (827) youth received family planning services while two hundred thirty-seven (237) participated in Teen Outreach Programs, fifty-nine (59) participated in male responsibility programs, and five hundred seventy-two (572) utilized Baby Think It Over simulators.

In March 2004 a request for proposal (RFP) for State Fiscal Year 2005 was disseminated targeting twelve (12) counties. Eleven County Coalitions responded and were awarded grants, including three (3) Hispanic Heritage (HH) applicants. Also funded to address unwed birth issues, HH grantees focus on the Latino population and are located in the Northwest, Southwest, and Central Public Health Regions of the State. Program requirements are the same as for the other County Coalitions.

6. //2008// The Family Health Branch is utilizing Health Connections Section to reach medicaid as an important subpopulation of its caseload. The activities of this Section, described above, provide new links and new ways to support Medicaid Recipients and potential recipients, especially women and children. This application reports on the populations served by the Medicaid Programs AR Kids A and B, Medicaid for Pregnant Women, the Family Planning Waiver, and a new target group brought in under the "Unborn Child Provision."//2008  
***An attachment is included in this section.***

## **C. Organizational Structure**

### **A. Introduction**

The Governor of Arkansas leads a Cabinet that included the former director of both Department of Health and the Department of Human Services. As of August 13, 2005, that arrangement will formally change. The Department of Health (ADH) will be merged with the Department of Human Services (DHS) to form a new Department of Health and Human Services in which the health agency will take its place as the Division of Health (DOH) beside related Divisions such as Developmental Disabilities (where the CSHCN program is now placed), The Division of Children's Services, the Division of Medical Services (Medicaid) and others.

The two departments have already co-located several administrative "like" functions with the intention of making them more efficient, and also strengthening them. Those functions include:

Legal Services - June 16

HIPAA Office - June 16

Payroll/Benefits (part of Financial Management) - June 21

Human Resources- June 21

EEO Office - July 1 (with a satellite office maintained at ADH)

Financial Management- July 5

The Board of Health remains intact in its membership and regulatory responsibilities in the new Department of Health and Human Services.

The Division of Health (DOH) will retain its existing regional configuration of counties. Divisions in the former DHS also had separate regional configurations. Each DOH region has a Regional Leadership Team headed by a Regional Director. These teams and directors provide supervision and guidance to District Managers within the Regions, who in turn manage the Local Health Unit administrators ( Hometown Health Leaders).

//2008// During the 2007 session of the Arkansas General Assembly, the members passed a law allowing the governor to separate the health agency from the human services agency, two agencies which were merged by the 2005 General Assembly. As of July 1, 2007, the Division of Health separated from DHHS, to become again the Arkansas Department of Health (ADH), a cabinet-level agency. This necessitates ADH re-building of agency-level infrastructure such as

financial management, human resources, information technology, and other administrative support services. The two new agencies are cooperating on this endeavor to make as smooth a transition as possible. While attention is being given to these administrative needs, programmatic needs are also being taken into account. Care is being taken that the inter-divisional processes set up for collaborative efforts which benefited from the unified organization will continue to flourish even though the departments are separate. ADH staff participate actively on the Early Childhood Commission (DCCECE), in the AECCS (CISS) process, in the System of Care for Mental Health process, in the ICC for Part C of IDEA, ANGELS (perinatal high risk referrals) and a host of other linking opportunities.//2008//

## B. Organizational structure by the MCH subpopulations

### 1. Pregnant women and infants organizational structure

//2008// The Perinatal Program is a part of the Women's Health Section of the Arkansas Department of Health. Women's Health is a section in the Family Health Branch of the Center for Health Advancement. The Perinatal Program provides support and guidance to the public health units through research, development, revisions and directing and assisting with the implementation of program policies and procedures. Women's Health Perinatal staff includes a chief physician consultant, who is board certified as a Fellow of the American College of Obstetrics/Gynecology and a BSN Registered Nurse, with extensive experience in maternal child care and public health. Advanced Practice Nurses and Registered Nurse Practitioners, along with the public health nursing staff provide clinical services at the local health units managed within the Women's Health Section.//2008//

//2008// The Perinatal Advisory Board was allowed to "sunset", effective July 1, 2007 by Act 153, due to a review of Government Efficiency and Accountability Subcommittee's recommendations. The Perinatal Advisory Board held its final meeting November 20, 2006. Prior to that Board attendance, for several meetings was insufficient to conduct business, and its recommendations seldom received attention from the governor and legislature. This Board was supported and coordinated by the Perinatal Program.//2008//

***//2009// The organizational structure of the Women's Health Branch remains the same.//2009//***

### 2. Organizational structure for children

//2007// The Child and Adolescent Health (CAH) Section of the Family Health Branch Houses children's health programs. Until recently, CAH was guided by a physician who is board certified in Preventive Medicine and clinically trained in pediatrics. That physician has resigned. The Division of Health plans to replace that position. Ms. JoAnn Bolick, a pediatric Advanced Practice Nurse with a Masters in Business Administration, who has served children in this agency for over 20 years, was appointed Section Chief for CAH. She will provide critical new leadership in programs for children. The Family Health Branch leaders intend the Section to bring new emphasis to developing interagency collaboration and broad partnerships in improving services for children. Heavy use of the Block Grant dollars to sustain the immunization program continues, but a new emphasis is being brought to Coordinated School Health, to Early Childhood Comprehensive Health Systems, and to outreach and case management. These emphases should all benefit from the merger of the two former departments. Three major developing partnerships for children include Coordinated School Health, Early Childhood Comprehensive Systems, and Child Mental Health Initiatives. //2007//

//2008// The Child and Adolescent Health Section of the Family Health Branch will be enhanced beginning July, 2008. The Board of Health and the state legislature have provided rules changes, budget authorization, and positions to expand the New Born Screening program from its current 9 conditions to encompass the 29 conditions currently recommended nationally for all states to

include in Newborn screening panels. A scientific "white paper" was produced in the summer of 2007, outlining a plan for the expansion and stating the need to increase the fee to \$89.25 per infant tested. In addition to PKU testing, tandem mass spectrometry will be added, checking for other aminoacidurias, fatty acid oxydation disorders, and organic acid disorders, as recommended. The fee will also include the addition of screening for Congenital Adrenal Hyperplasia, Cystic Fibrosis, and Biotinidase. July 1, 2007 will see the beginning of recruitment of needed additional follow-up staff, including a .5 FTE pediatrician, and full-time staff including a Program Nurse Manager, two additional nurses, an LPN, an administrator, and a database manager; and additional laboratory staff to accommodate the added lab testing procedures. The current plan is to cover the other .5 FTE of the pediatrician to guide other child health programs, but especially to pay attention to interagency collaborative efforts that enhance the system of care for children. //2008//

***//2009//Expansion of the Newborn Screening Program to detect the 29 nationally recommended conditions began as of July 1, 2008. The State Laboratory is now screening for all 29 conditions, and billing for the new \$89.25 fee. In June The Family Health Branch hired J. Robert West, MD, MPH, a board certified pediatrician who is very knowledgeable about Newborn Screening and has previously served in the agency. The CAH Section has hired two new public health nurses as Newborn Screening Consultants, and is finalizing hiring of the administrative nurse to guide the staff effort and another public health nurse to also assist with follow-up. ADH has signed a contract with the UAMS Department of Pediatrics for the medical guidance and technical assistance needed to manage the screening and diagnostic process. A contract is planned with Arkansas Children's Hospital covering arrangements for second tier testing. Detailed protocols have been written, and will be adjusted as needed.//2009//***

***//2009// Dr. West was hired full time into the position of the Deputy Chief of the Family Health Branch. As the activities of the Newborn Screening Program become more routine, Dr. West will assume medical leadership of all CAH Programs.//2009//***

### 3. Organizational structure for Children with Special Health Care Needs

Historically, in Arkansas the Title V CSHCN program has been housed in DHS. The transfer of the Title V CSHCN program (formerly known as Children's Medical Service or CMS) from the Division of Medical Services (Arkansas' Medicaid entity) to the Division of Developmental Disabilities Services led to reorganization within DDS to structure the agency into Children's Services and Adult Services with other sections providing fiscal management and quality assurance resources. Prior to the intradepartmental move, the Title V CSHCN program and DDS served many mutual consumers. DDS had and still has a scope of eligibility that includes Cerebral Palsy, Seizures, Autism, Mental Retardation and any "other condition" that causes an individual to function as though they are Mentally Retarded. The Title V CSHCN program covered Cerebral Palsy, Seizures and some of the "other conditions", but did not cover Autism and Mental Retardation. Title V CSHCN, following national definitions, covered and still covers a wide range of medical conditions such as Cancer, type I Diabetes, severe Asthma, Spina Bifida, orthopedic anomalies, injuries and many, many other conditions. These conditions are outside the range of typical DDS consumers so that the DDS scope of service is somewhat narrower than CSHCN. As the Title V CSHCN staff transitioned into DDS they have been assigned duties and caseloads for other DDS programs. These programs provide services to CSHCN and are an additional resource for families.

Although there are more employees, the combined caseloads remain too large for staff to effectively manage. This has led to concerns among veteran Title V CSHCN staff, the Parent Advisory Council and others that traditional Title V CSHCN consumers are being neglected. Using the long-held definition of CSHCN, all of the individuals served through the DDS programs are children with special needs and are deserving of Title V CSHCN staff efforts to assist in meeting their needs and personal goals. The over-riding issue is whether it is realistic to believe

that a relatively small staff can adequately handle the caseloads that result from these various programs.

//2008// As of this writing (June 2007), possible reassignment of CMS Care Coordination staff to focus on medically complicated children with special health care needs is under consideration.//2008//

**//2009// The reassignment of Part C Early Intervention job tasks took place as planned allowing all except four of the care coordination staff to concentrate on work with medically complicated and developmentally delayed children, youth and their families. At this time, two of the care coordinators continue to work with the Part C program until that program is able to hire staff.//2009//**

#### 4. Organizational structure for WIC services

The WIC Program, along side the Women's Health and Child and Adolescent Health Work Units, is housed in the WIC Work Unit of the Family Health Services Unit. WIC clinic services are provided in all 94 local health unit sites, as are food instrument services. Farmers' markets are developed in selected sites in the state. The WIC Work Unit is supported by the Regional Leadership Teams who assure management through the District Managers and Administrative Leaders of Local Health Units.

//2007// The WIC Program is now placed as a Branch within the Center for Health Advancement, and will house the leadership of nutrition services as well. Mr. Marcell Jones serves as its Associate Chief, and a Chief is being recruited.//2007//

//2008// WIC staff has been working diligently on the development of Value Enhanced Nutrition Assessment (VENA). A new process of doing nutrition assessment in WIC. They will be adopting the health outcome based nutrition assessment. This for all patient types. //2008//

**//2009// Current Agency structure, moving from Section Chief related to mothers and children upward, the leading staff includes: In Health Connections - Mary Gaither, an experienced public health nurse administrator; in Women's Health - Sharon Ashcraft, an experienced public health maternity nurse and RNP; in Child and Adolescent Health - JoAnn Bolick, a pediatric nurse practitioner with long experience in program administration. In Family Health - Mr. Bradley Planey is Associate Branch Chief and has experience administering mental health, family planning, maternity and abstinence education programs; Robert West, MD MPH is Deputy Branch Chief with many years experience in managing child health programs especially Newborn Screening; and Dick Nugent MD MPH Branch Chief, with vast experience leading MCH programs. At this time, all Sections staffs are complete with the exception of the managing nurse for the NBS expansion (Recruitment in process) and two help line specialists in Healthy Connections. After July 1, six new positions are funded from Medicaid to enhance outreach to Medicaid eligible children.//2009//  
An attachment is included in this section.**

## D. Other MCH Capacity

### 1. Introduction

//2008// In the interests of brevity, clarity and space, this section has been modified from earlier applications by removal of out-dated organizational descriptions. Other capacities in the Arkansas Department of Health (ADH) include staff in Centers other than the Center for Health Advancement (where MCH is administered) that work on or collaborate with MCH programs. The Center for Health Protection is headed by Mr. Donnie Smith, a professional health educator who has had long experience with management of many health programs. In the past, Mr. Smith

served as the Administrative Director of the MCH programs. He is assisted by Dr. James Phillips as Associate Director for Science, and Mr. Ron Stark as Associate Director for Management and Operations. Mr. Stark has long experience with management of MCH programs in the Department, and also with management of Medicaid programs in DHS that relate to women and children. //2008//

//2008// The Center for Health Statistics (SCHS) manages many data bases that are of critical importance to MCH, especially birth and death certificates, hospital discharge, PRAMS, BRFSS and local YRBS data bases. SCHS also manages professional registries for licensed health professionals. The Center, now called the Health Statistics Branch in the Center for Health Practice maintains a staff of highly skilled statisticians who are trained in SAS software use. They assist epidemiologists and program directors with data needs for agency performance, strategic planning, and program registries such as cancer and immunization. The SCHS manages the State Systems Development Grant (SSDI) which supports a rich network of data linkages being developed by the Health Department. For example, with SSDI and other resources have enabled SCHS to link birth certificates to infant death certificates, hospital discharge data, PRAMS survey data, Medicaid enrollment and billing information, and a variety of other data sets. The SSDI grant, along with other resources provides as much state data capacity as programs can use. The 2006 block grant application, requiring the 5 year needs assessment, called for a number of new measures. The SCHS was able to respond to these requests in a very timely manner with up-to-date information.//2008//

***//2009// The Center for Health Practice, Headed by Dr. Glen Baker, houses the Epidemiology Branch composed of Senior Epidemiologists serving all programs of the ADH. Ms. Terri Wooten is located in this Branch. Ms. Wooten serves as the MCH Epidemiologist and provides major assistance in developing the MCH Block Grant applications.  
//2009//***

2. Other MCH capacities can also be described by the MCH subpopulation group.

a. Infants and Pregnant Women

The OBGYN and Pediatric Departments of UAMS provide medical leadership for infants and pregnant women that extends to all parts of the state. The Maternal and Fetal Medicine (MFM) faculty, and the Neonatology faculty, provide medical training for obstetricians and pediatricians who graduate from residency training to practice in larger communities. The two subspecialty faculties also conduct an annual Perinatal Conference in Little Rock, attended by obstetricians, pediatricians, and family physicians, as well as hospital and office nurses in relevant practices. With contractual support from the Division of Health, the MFM Division provides outpatient clinic services for pregnant adolescents, and a special clinic for pregnant women with gestational diabetes. These clinic services and the prenatal clinics in local health units throughout the state are served by a coordinated system for consultation and referral operated by the high risk maternity services of UAMS. The Directors of the Maternal Fetal Medicine and Neonatology Divisions, with financial support from the Medicaid Program, have begun an effort called Antenatal and Neonatal Guidelines for Education and Learning Systems (ANGELS). ANGELS has many purposes and activities. Among them is a statewide telemedicine network for obstetricians and neonatologists. This network holds conference every Thursday morning at 7:00 AM to present cases, discuss new evidence-based guidelines for obstetrical and newborn care, and to include community physicians in the process of writing the ANGELS guidelines. They are published both on the UAMS web page and by distribution of written copies to physicians in appropriate specialties. MCH staff from the DOH actively participate in these efforts.

The Community Health Centers Program of the Division, aided by the Primary Care Association of Arkansas, develops and maintains the network of 51 Community Health Centers throughout the state.

Many of these Centers provide obstetrical care, and are located in medically under-served counties. The Area Health Education Centers train family physicians and also provide training in obstetrics, including the ability to perform cesarean sections for those physicians interested in this practice. While the AHEC's primary objective is training, a significant capacity to provide prenatal care exists in the AHECS in certain communities. The Primary Health Care Association supports the Statewide Health Access and Resources Program (SHARP), a collaborative planning and policy development group intended to bring together HRSA funded programs in the state. MCH staff participate actively in these efforts.

//2008// The University of Arkansas for Medical Sciences Obstetrics /Gynecology and Pediatric Departments provide medical leadership for infants and pregnant women that extends to all parts of the state and beyond. The Arkansas Department of Health and Human Services, Division of Health provided for 84 hospitals to receive teleconferencing equipment through a Health Resources and Service Administration National Bioterrorism Hospital Preparedness Program grant. UAMS ANGELS provides a weekly telemedicine conferences to enable physicians to confer with maternal-fetal medicine specialists in real-time about individual cases. In addition, ultrasounds can be read in real-time, and ANGELS offers assistance in training local technicians. Clinical telemedicine consultations are available that allow patients, local physicians, and UAMS physicians to talk together and see each other, bringing subspecialty support directly to hometowns. Three teleconferences are offered at this time: High Risk Obstetrics, ANGELS Neonatal and Obstetrical Nursing Exchange (ONE). The High-Risk Obstetrics Teleconferences are offered every Thursday, the ANGELS Neonatal Teleconference is held on the third Thursday of every month, Obstetrical Nursing Exchange (ONE) is held on the first Friday of every month. Plans are in the making for an additional teleconference, FAIM, or Fetal Anomaly Interdisciplinary Management, that will be held monthly via teleconference at several locations around Arkansas, including UAMS and Arkansas Children's Hospital. ANGELS also provides a call center to provide 24-hour support for physicians to consult with maternal-fetal medicine specialists when requested regarding patient management issues.//2008//

***//2009// Dr. Richard Nugent, Family Health Branch Chief, also serves on the Evaluation Team for the ANGELS Program, which is also greatly assisted by Dr. John Senner of the ADH Health Statistics Branch. That evaluation is funded by Medicaid (CMS), and is contracted to a nationally recognized Epidemiologist, Dr. Janet Bronstein of the University of Alabama at Birmingham. The evaluation team meets weekly by telephone.//2009//***

//2008// The Women's Health Section, Perinatal Program, provides the semi-annual Maternity Training Program for Public Health Nurses. These trainings were held February and August 2006. This is a continuing education opportunity to provide the skills and information needed by Public Health Nurses to obtain histories, identify problems and make proper referral for the pregnant women in our maternity clinics. Public Health Nurses and Maternal Infant Nurses from throughout the state attend this four day training in Little Rock. Nurses earn Continuing Education Contact Hours approved by the Arkansas Nurses Association. The training is primarily focused on nurses new to the provision of maternity services, with an average of eighteen to twenty two participants. The presenters are experts in the field of maternity care from the Division of Health, UAMS, and other health care providers. The nurses attend the ANGELS ONE teleconference as one of the training sessions.

//2008//

#### b. Children's Services

//2008// The Department of Health contracts with the Department of Pediatrics at UAMS for certain services to children. Primarily this contract is intended to provide coordination of hospital discharge plans for newborns leaving neonatal intensive care. The Pediatric Department's Neonatology services work very closely with the maternal fetal medicine services to coordinate perinatal services at UAMS. The two services together mount an annual perinatal conference training over 300 health professionals, mostly doctors and nurses, regarding new developments

in perinatal medicine, and in the development of programs for infants and pregnant women.//2008//

***//2009// This year a significant new contract was established with the UAMS Department of Pediatrics to provide medical specialty guidance and technical assistance for the expansion of the Newborn Screening Program.//2009//***

//2008// The ADH and DHS in their former arrangements have had an ongoing liaison committee that met on an approximately monthly basis. In the new Department of Health, this function will happen more routinely during regular meetings of the Division Directors.//2008//

***//2009// Relationships between the now-separate Department of Health and Department of Human Services (DHS) are maintained by meetings, as needed, between the ADH and DHS executive staff. Many new grants and strategic planning opportunities have occasioned meetings at this level.//2009//***

//2008// The Arkansas Children's Hospital (ACH) is among the top children's hospitals in the country. It provides subspecialty care, conducts research, and assists with public awareness and promotional aspects of developing services for children. ACH has developed outreach clinics for many pediatric specialties in more rural areas of the state. In addition to the Pediatric Department of UAMS, ACH is the main institutional provider of highly specialized pediatric services in the state. ACH operates a helicopter transport system for emergency evacuation of sick newborns. //2008//

***//2009// With the expansion of the Newborn Screening Program to the recommended 29 conditions, detailed negotiations and collaboration have occurred with the Arkansas Children's Hospital, especially its Laboratory concerning second tier screening tests, and referrals to subspecialty clinics.//2009//***

#### c. Services for Children with Special Health Care Needs

The Director of the Division of Developmental Disabilities Services in DHS is James C. Green, PhD. His background is in Special Education. Current program leadership includes Regina Davenport, Assistant Director for DDS Children's Services. Ms. Davenport has a B.S. in Psychology from Arkansas State University with post-graduate work in counseling and Special Education. Her professional background is in developmental disabilities. Nancy Holder, RN, Program Administrator has an Associates Degree in Nursing from Memphis State University. Her professional background is in CSHCN, typically the medically involved child and youth. Eldon Schulz, M.D. with the University of Arkansas Medical Sciences Department of Pediatrics is currently serving under contract as Medical Director for the Title V CSHCN program. His professional background is in Developmental Pediatrics.

//2007//There has been a change in leadership within the Division. Mike McMillan currently serves as the Assistant Director of the Division of Developmental Disabilities Services, overseeing the Children's Services Unit. Mr. McMillan is a Licensed Social Worker with experience in child abuse and neglect investigations; serving in various positions at several Intermediate Care Facilities for the Mentally Retarded and as Executive Director for a private, non-profit agency serving children and adults with developmental disabilities. //2007//

Since the transfer of the Title V CSHCN program from DMS to DDS, the make-up of the casework staff has expanded. A statewide Regional Management team of six includes four Registered Nurses, one Social Worker and one Service Specialist. Each of these Regional Managers supervises employees that include Registered Nurses, Social Workers and Service Specialists. Title V CSHCN staff are housed in 26 of the 75 counties in the state in DHS-operated offices. The RNs on staff have a minimum of two years experience when hired, with the current average years of experience with CSHCN being 19 years. The Social Workers on staff are

licensed Social Workers or are individuals that have education and experience with CSHCN and are in positions which allow them to function in a Social Work capacity. The Service Specialists must have either a BS or BA degree with 2 years experience working with the developmentally disabled. The Title V CSHCN program currently has on staff: 22 Clerical Staff; 15 Registered Nurses, 7 Social Workers, 9 Service Specialists and 1 Psychological Examiner in community-based offices. There are 8 Management staff with 4 housed in community-based offices and 4 in central office. There are 23 Central Office support staff (administrative and clerical). Of the 85 total employees, 8 have children with special health needs. One is the Parent Consultant, 3 are Registered Nurses, 2 are Social Workers and 2 are Service Specialists.

//2007// Over the past year, our staff has decreased due to retirements and resignations. Replacement of those employees was postponed until after July 2006. We anticipate rehiring staff in the first quarter of the state fiscal year. There are currently 71 employees on staff either full or part time. Of those employees, 9 have children with special health needs. This includes the Parent Consultant, 1 Registered Nurse, 2 Social Workers, 3 Service Specialists and 2 clerical staff. //2007//

Rodney Farley serves as Parent Consultant for the Title V CSHCN program. In this position he serves on a number of committees as a parent of a child with special needs and as an advocate. The committees he serves on include Partners for Inclusive Communities (Arkansas' University Affiliated Program) Consumer Committee; Arkansas Parent Information Exchange; Parent Training Information Governing Board; Advocates Needed Today (ANTS); Can-Do Committee; Parent Educator Advisory Committee; Arkansas Children's Hospital Rehab Advisory Committee and he serves as Family Voices Region VI Coordinator. Rodney works with the Title V CSHCN Parent Advisory Committee. As the parent of a young adult with special health care needs, he is able to give advice and assistance to parents with children of all ages.

The Parent Advisory Committee (PAC) for the Title V CSHCN program was formed 15 years ago and involves volunteers from around the state that are parents of CSHCN. The PAC meets quarterly. The PAC members are responsible for setting up local meetings to take information to more parents and work to set up support groups around the state.

***//2009// The Title V CSHCN program staff is experiencing minor personnel changes related to retirement of long-time staff. Rehiring is in process at this time.//2009//***

## **E. State Agency Coordination**

### **E. State Agency Coordination**

#### **Introduction**

//2008// In its 2007 session, the Arkansas General Assembly authorized the Governor to separate the Department of Health and Human Services (DHHS) to form the Arkansas Department of Health (ADH) and the Department of Human Services (DHS). The Governor ordered the separation. Below, descriptions of the DHHS have been removed in the interests of clarity and brevity. Those descriptions may be referenced in last year's application. Mr. John Selig continues to direct DHS and Dr. Halverson continues to lead the ADH and its relationship to the Legislature. Also, the Board of Health remains largely intact and will relate just as closely to the ADH. Dr. Joe Thompson has been named State Surgeon General, a role in which he will serve as a policy consultant to the Governor and Senior State Agency Officials, be a non-voting member of the Board of Health and perform other advisory functions. Both Dr. Halverson and Dr. Thompson will have cabinet-level positions. Because all leaders remain committed to continued collaborative relationships, we believe that any impact on programs will be minimal. ADH will relate directly to the Department of Finance and Administration for budget and personnel decisions. A new table of organization is appended. //2008//

State agency coordination exists on many levels including state government human service

agencies, state-level commissions and partnerships (both existing and developmental), state-local health agency relationships, and local human-services agency interactions.

#### State government and human services agencies

//2008// Despite the separation of the DHHS, three important partnerships continue to develop - The Child Mental Health System of Care Initiative, the Arkansas Early Childhood Comprehensive Systems, and the Coordinated School Health partnerships. Developments in these areas are described in later sections of this application. //2008//

#### State-level commissions, partnerships and advocacy groups

Among many such groups, a few stand out as being particularly important. Longstanding commissions include the Commission on Child Abuse, Rape and Domestic Violence and the Child and Adolescent Service System Program (CASSP). They bring policy and public prominence to these issues. The Arkansas Advocates for Children and Families has played a major role over the years in public policy for the needs of children in general. The Interagency Coordinating Committee was established for IDEA and continues to help state agencies collaborate around the educational and health needs of at-risk children.

***//2009// Dr. Nugent participates as a member of the CASSP Coordinating Committee, and as a voting member of the Early Childhood Education Commission. He also serves as the Medical Home Committee Chair for the Arkansas Early Child Care Comprehensive Systems (AECCS) planning group, and on the Stakeholders' Committee for the Assuring Better Child Development Technical Assistance grant. Ms. JoAnn Bolick serves on the Core Team for AECCS. Dr. Nugent also represents the ADH on the Child Health Advisory Committee (CHAC) described below, and participated actively in the interagency planning effort that initiated the System of Care for Children's Mental Health. Ms. Bolick and the Child and Adolescent Health Section staff provide administrative support for the CHAC. //2009//***

Several developmental state partnerships and institutions are making great strides in collaborative efforts for children. Among them the most prominent as a new effort is the Child Health Advisory Committee (CHAC). ACT 1220 of 2003 created this group to address childhood obesity and develop statewide nutrition and physical activity standards. The Committee meets monthly and makes policy recommendations to the State Board of Education and the State Board of Health. Major tasks mandated by the Act include: 1) Removing elementary school student in-school access to vending machines offering food and beverages; 2) Developing recommendations to ensure that nutrition and physical activity standards are implemented to provide students with the skills, opportunities and encouragement to adopt healthy lifestyles; 3) Requiring schools to include as part of the annual report to parents and the community the amounts and sources of funds received from competitive food and beverage contracts; 4) Requiring schools to include as part of each student's health report to parents an annual body mass index (BMI) percentile; and 5) Requiring schools to annually provide parents an explanation of the possible health effects of body mass index, nutrition and physical activity. Organizational memberships in the CHAC include: Division of Health, Dietetic Association, Academy of Pediatrics, Academy of Family Practice, Association for Health, Physical Education and Dance, Heart, Cancer and Lung Associations, College of Public Health, the Arkansas Center for Health Improvement, Arkansas Advocates for Children and Families, U of A Cooperative Extension Service, Department of Education, School Food Services Association, School Nurses Association, the Association of Education Administrators, and the Parents and Teachers Association. The CHAC made strong recommendations to the Department of Education, and the Department Adopted regulatory requirements with direct impact on the nutritional environment in schools.

//2008// The CHAC now provides guidance for the Coordinated School Health Program, funded

by CDC, as well as the requirements of Act 1220. The 2007 session of the General Assembly made several significant changes in the rules promulgated under Act 1220. BMI measurements are to be made only every other grade, and the total time required for students to be involved in physical activity has been reduced. The BMI measurement change will have only a minimal affect on the ability to assess program impact, because measurements will still be made every year, just not in every grade. The reduction in required physical activity may have a more problematic impact, long term. //2008//

//2008// The CHAC has developed a sub-committee to address the Arkansas Early Childhood Comprehensive Systems partnership. The sub-committee keeps the CHAC updated on progress toward the implementation of the Quality Rating System (QRS) being developed for Early Childhood Education providers. A five-tiered QRS for all aspects of ECE, and including a comprehensive set for health issues, has been proposed, "vetted" with leaders of ECE providers in the state, and is taking a more settled form. Very detailed work with ECE providers has brought the focus to clear, operational, and realistic expectations for the first three tiers of the guidelines. The Division of Child Care and Early Childhood Education that licenses day care centers, has assumed the leadership of applying these as voluntary guidelines, and has even identified funds to incentivize providers to enhance their services. //2008//

***//2009// Out of the collaborations developed by the Early Childhood Comprehensive Systems (AECCS), The Assuring Better Child Development (ABCD), and System of Care for Children's Mental Health (SOC) planning processes, an interagency committee was formed which wrote and submitted a grant application for Project LAUNCH. The project envisions creating an Early Childhood Partnership Council to coordinate the many streams of public and private interests in children 0-8. The Council will be initiated whether or not the grant is funded. Funding will be used primarily to coordinate services at the community level for young children.//2009//***

In 2002 the University of Arkansas for Medical Sciences (UAMS) announced the opening of the College of Public Health (COPH), in partnership with the Arkansas Department of Health. This summer (2005) the COPH will be dedicated and named in honor of the late Fay Boozman. The COPH includes the shared missions of 1) meeting the public health workforce needs for the future and 2) demonstrating how public health approaches can address the health needs of Arkansans via model community programs. Pilot sites for teaching and learning also serve as innovative laboratories for new and creative approaches to old problems. Students learn, with the expert aid of local citizens, schools, hospitals, and faith groups about community-based health improvement. The COPH statewide approach to education includes partnerships with other universities and institutes of learning. For example, students may choose from approved courses at any of several state universities, or via the Internet from an even broader range of course options. During the 2003-2004 academic year, the COPH offered a Post-Baccalaureate Certificate, Master of Public Health (MPH), and DrPH in Public Health Leadership degree programs.

As with other UAMS colleges, the standards of teaching and learning are high and the resources for academic and social life are excellent. The mission of the College of Public Health at UAMS is to improve health and promote well-being of individuals, families, and communities in Arkansas through education, research, and service. The College of Public Health has elected to address its mandate to improve the health of Arkansas by adopting a community-based health education model. The long-term vision is of "optimal health for all Arkansans." By joining forces with pilot communities, the College establishes a model process for statewide health improvement. COPH students, faculty and staff participate in close partnership with local organizations, citizens and public officials. In-service teaching and learning opportunities for COPH students will be concentrated in these pilot communities to the benefit of all involved.

//2008// In the Fay W. Boozman College of Public Health (COPH), two new PhD programs, one in the Department of Health Policy and Management, and one in the Department of Health Behavior and Health education have accepted students and are conducting classes. Having accomplished

these new degree programs, the CPH passed its second review by the national Council for Education in Public Health (CEPH), its accrediting body. That accreditation will continue for five years.//2008//

//2007// Formerly an academic department at the College of Public Health, the Maternal and Child Health teaching program has been reorganized. The MCH Department is now the Center for MCH Studies at the college, and its course offerings have been migrated to the Department of Health Policy and Management, and the Department of Health Behavior and Health Education. Dr. Richard Nugent serves as the Director of the Center for MCH Studies. //2007//

//2008// Dr. Nugent continues to direct the CPH Center for MCH Studies. Four of the five courses taught as an MCH Department are planned for presentation in the 2007-08 academic year, two in the fall and two in the spring. The one course not taught was an overview of all the MCH courses. Student enrollment in these courses have not been large. When enrollment fell below 5 students for a course, it was taught instead as a directed study, still at 3 credit hours. Although the CPH budget has increased incrementally, most of that income is directed to public health research. However, as Tobacco dollars decline, and as funding support from UAMS for faculty and teaching does not increase, money is more scarce than ever before.//2008//

***//2009// With severe budget cutbacks for the College of Public Health, the full-time faculty position supporting the MCH Courses was discontinued, and its incumbent found other work. As a result the major faculty support for MCH Courses was lost. It is not anticipated that an MCH Course will be taught in the fall. Dr. Nugent will continue his appointment with the purpose of developing a 5-year plan to return the MCH presence in the CPH to departmental status. Meanwhile, he is devoting more time to assisting the ANGELS evaluation for the College of Medicine Department of OBGYN.//2009//***

//2008// State/Local coordination in the organizational structure of the new ADH will remain the same. The five organizational units under the Executive Staff remain the same: the Centers for Local Public Health, Health Advancement, Health Protection, and Health Practice; and the State Laboratory. The Center for Local Public Health administers the Regions, Districts, and Local Health Units. Within the Center for Health Advancement the Family Health Branch (administering the MCH Block Grant) will relate even more closely to its sister Branches of WIC, Oral Health, Chronic Disease, Tobacco Control, and Life Stages. Together, more of the Centers' programmatic supports for local communities is being administered through grants to community lead agencies. //2008//

//2008// With the effects of the influx of Hurricane Evacuees receding in time, local health unit efforts have returned more to a normal state. However, they continue to be involved in local planning teams for all-hazards emergency response, and with the Bioterrorism programs of the Center for Health Protection. //2008//

***//2009// In addition to the Executive Staff and Senior Staff meetings of the agency, two other forums exist to help Centers collaborate. The Scientific Advisory Committee develops and assures the use of the public health evidence base to support the assessment, policy and assurance functions of the ADH. Dr. Nugent serves on that group as Associate Director for Science with the Center for Local Public Health. Also, the Doctors' Horizontal Team provides links among agency medical professionals including physicians, dentists, veterinarians and other doctoral- level personnel. This year a "sister" Branch in the Center for Health Advancement conducted a major planning effort called the Chronic Disease Forum. Dr. Nugent attended events in that planning effort.//2009//***

#### CSHCN STATE AGENCY COORDINATION

In its relatively new location in the Division of Developmental Disabilities in DHHS, the Children's

Medical Services (CSHCN) Program is working more closely with other programs for developmentally disabled children, and with Medicaid. Arkansas Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is currently undergoing a revitalizing effort to increase screens through increased information sent to families and providers in mailings from the Medicaid contractor. These efforts should help increase EPSDT screenings. The Title V CSHCN staff routinely monitor the screens for the children and youth for which we are responsible for case management. When the EPSDT screening responsibilities were given solely to the Medicaid recipient's primary care physician, the DOH ceased providing the EPSDT services in areas of the state that were not medically underserved. This has led to difficulty in getting timely screenings done due to heavy physician schedules. Quite often, the screens are not billed as EPSDT and it is therefore difficult to monitor the periodicity rates and follow-up. While this is a reporting problem, the child has in fact received the well-child care they need. The new structure of the Department of Health and Human Services offers an opportunity for closer coordination between MCH Programs and Medicaid, especially the coordination of the two former Department's information technology systems.

Especially active is another new collaboration closely related to the CMS program. Supported by a grant from HRSA called the Arkansas Early Childhood Care and Services (AECCS) Program, this new collaboration has a steering committee and subcommittees addressing Socio-emotional Development, the Medical Home, and Tiered Quality Services. These groups have begun to articulate recommendations in all these areas, and are moving to implement for effective partnerships in these areas. A statewide conference is being planned which will bring together educators, day care center operators, physicians, early childhood programs and especially parents to strengthen these relationships. Leaders from the Division of Health have also been active on these committees.

Within the former Department of Human Services there has been an important "division of labor" to accomplish the case management needed by many CSHCN families. The 4 CMS nurse coordinators covering the state have heretofore targeted their efforts to supporting families who did not have Medicaid among whom are many that have very little health insurance. There are a much larger number of DHS case-managers who can provide these enabling services to families who do have Medicaid coverage. By this plan, all 26 areas of the state can be covered with case management services.

***//2009// Nancy Holder, Program Administrator for the Title V CSHCN program, now serves on the Executive Council of the Child and Adolescent Service System Program (CASSP) with the merging of the Together We Can and CASSP programs, effective 7/1/08. She is also a member of the ABCD Stakeholder's Group, the AR Kids Count Finish Line Coalition and the Oral Healthcare Advisory Committee. She attends the Governor's Roundtable on Healthcare as an interested observer. The Title V CSHCN Parent Coordinator, Rodney Farley, is active in Family Voices, serves as Chair of the UAMS Partners for Inclusive Communities Consumer Advisory Council, serves on the Parent as Educators Advisory Committee at AR Children's Hospital, serves as a board member of the AR Disability Policy Consortium. //2009//***

## **F. Health Systems Capacity Indicators**

### **Introduction**

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>

Annual Indicator	27.6	27.4	26.9	22.3	22.3
Numerator	513	508	504	430	430
Denominator	185941	185555	187377	192891	192891
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

#### Notes - 2007

2007 indicator pre-populated with 2006 data, as 2007 Hospital Discharge data is not available.

#### Notes - 2006

2005 population estimate 0 - 5 years used for 2006 indicator

Declines in admissions of children for asthma are consistent with a statewide public awareness campaign called "Don't Let Asthma Slow You Down," and a parallel professional education campaign about the usefulness of adding anti-inflammatory medications to regimes of bronchodilator inhalation therapy for symptomatic asthma, and awareness of the need for medical care for this common disease in childhood. These efforts began at least 4 years ago with a major initiative of the AFMC (Arkansas Foundation for Medical Care - the state's Professional Review Organization)

#### Narrative:

Professional education, and public awareness messages on TV entitled ("Don't let asthma slow you down"), have spread knowledge of the value of steroidal and other anti-inflammatory inhalers for the management of asthma. It is better known that bronchodilators only treat one aspect of the complicated patho-physiology which leads to symptomatic asthma. Environmental knowledge about roach infestation and its relation to asthma in children has also received attention in Arkansas. The State Systems Development Initiative grants over the years have added immeasurably to the Center for Health Statistics' ability to link important databases for vital records, hospital discharge, PRAMS, and BRFSS. This linking has been especially informative to the MCH Block Grant monitoring process for other specific indicators which will be discussed with those indicators.

**//2009// Hospital discharge data files will not be finalized until late July. As a result, we have "prepopulated" the data reported above with information from last year.//2009//**

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	95.9	63.2	63.2	75.2	75.5
Numerator	20726	15932	15932	20544	22003
Denominator	21617	25225	25225	27311	29146
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

#### **Notes - 2007**

Data source: FY 2007 Medicaid claims.

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

#### **Notes - 2006**

Data source: FY 2006 Medicaid claims

AR Kids First program expansions on Medicaid are reaching more children.

#### **Notes - 2005**

Data source: 2004 medical records survey not repeated in 2005.

#### **Narrative:**

//2008// On the surface it is encouraging to see the indicator for access of enrollees to primary care improving. However, this indicator continues to be somewhat complicated in Arkansas. As leaders of the MCH Block Grant, ADH personnel do not have a "clear line of view" into how these data are generated. Physicians' offices have a variety of ways in which they fulfill Medicaid's expectations for "periodic screens" and "developmental assessments," as distinct from an episodic visit. The development of the Medical Home in Arkansas was initiated through two activities: 1) a residency training module for pediatrics and family practice on the subject at UAMS, and 2) regional talks throughout the state given by the prior Medical Director for Children's Medical Services. His replacement, a sub-specialty boarded developmental pediatrician at Arkansas Children's Hospital has also provided this education. The residency training program has been producing physicians who are well aware of the concepts and ideals of the Medical Home, yet the process of actually carrying them out in practice, including effective screening techniques for developmental assessment, has not been standardized in Arkansas. The Area Health Education Centers' Regional Medical Program regularly sponsors CME sessions on a variety of topics, one of which has been the Medical Home; however, the degree to which this training has resulted in changes in practice can not be well measured from our database. Medicaid can count the number children for whom an EPSDT visit was paid for, or the number of initial visits for children once enrolled in Medicaid, but these are rough tools, and inadequate to gather the information needed to assess the characteristics of care given. Toward this end, Arkansas is participating in a program called the "Assuring Better Child Development" (ABCD) technical assistance opportunity sponsored by HRSA. A team of state child health leaders, including Medicaid, Health, Child Care and Early Childhood Education, the Child Development sub-specialist at Arkansas Children's hospital, and the executive staff person of the Arkansas Chapter of the American Academy of Pediatrics have formed a "core team" in anticipation of attending this national technical assistance opportunity. A support group including a wide variety of health and social services leaders has been gathered in anticipation of the return of the Core Team to begin coordinated planning. Bright Futures, the Academy of Pediatrics' new guidance in this area, and the results of pilot projects in North Carolina, Vermont and elsewhere, will be utilized in this technical assistance opportunity.

***//2009// Data on receipt of an EPSDT "periodic screen" shows an increase in both numerator and denominator numbers consistent with growth in the enrollment for AR Kids A and B (Medicaid and SCHIP). The percentages of children receiving a periodic screen are consistent and even showing a slight increase. This represents better data than previous years. The improvement in the data and the slight increase reflects a strong involvement by the Medicaid Program in following this measure. Medicaid contracts with***

*the Arkansas Foundation for Medical Sciences (AFMC), formerly the PRO, to have its employees make annual visits to most Medicaid Primary Care Physicians with the emphasis on those providing care for children. Functioning like "detail agents" for pharmaceutical and formula companies, these workers make contact with doctors and their office personnel to explain Medicaid programs and provide technical assistance with billing and policy issues. AFMC staff are now actively involved supporting two pilot projects in physicians' offices to apply the Ages and Stages Questionnaire (ASQ), a validated and popularly used tool for general developmental screening. Currently, with the help of the AFMC staff and Medicaid, the Assuring Better Child Development (ABCD) planning group is starting on a "Statewide Spread Strategy" to extend developmental screening by a validated tool to 30 or more Primary Care Physicians' offices in the next year. Medicaid has further detailed its billing codes to provide specific reimbursement for these services.//2009//*

*//2009// The ADH, with major collaboration from the DHS, especially its planners and leaders for Behavioral and Early Childhood Education Divisions, made application to the Project LAUNCH grant program, a joint effort of SAMHSA and HRSA (MCHB). This grant envisions creating an Early Childhood Partnership Council, and will be working with a pilot project in the town of Stuttgart in Arkansas County. The Family Physician there, Dr. Dennis Yelvington, is now one of two practices implementing the Ages and Stages Questionnaire for developmental assessment, as a pilot for the Assuring Better Child Development initiative. That practice will add the Socio-Emotional scale in ASQ.//2009//*

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	60.5	8.0	8.0	61.4	62.7
Numerator	118	66	66	522	602
Denominator	195	823	823	850	960
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

Data source: FY 2007 Medicaid claims

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

**Notes - 2006**

Data source: FY 2006 Medicaid claims

ADH staff continue to seek better information from Medicaid's data contractor. Collaborative efforts have again improved this year, so we hope to have clearer information in the coming years to really evaluate this trend.

**Notes - 2005**

Data source: 2004 medical records survey - not repeated in 2005.

**Narrative:**

//2008// As with other indicators of this nature, ADH MCH leaders continued to have questions about how this data was gathered and assessed. Conversations with Medicaid's data contractor, EDS had begun in which a more detailed understanding of this information is being sought. At least two ways of arriving at this information occur in Arkansas: 1) EDS can produce the information on the % of enrollees under age 1 (either Medicaid or SCHIP) who have had a billed and paid EPSDT visit. This still leaves ADH unclear about what has been accomplished during those billed visits. 2) Perhaps a more detailed look had been made by the Arkansas Foundation for Medical Care as the Physician's Review Organization for the state. AFMC has access to physicians' office medical records. AFMC accesses a sample of records from medical offices and queries those records for the assessments required by EPSDT in their developmental assessments. In years 2004 and 2005, the AFMC data was reported above. In the years 2003 and 2006 the EDS data have been reported. Neither one, in our view, fairly reflects the services given to Arkansas's children. Perhaps Arkansas's planned attendance at the ABCD national technical assistance opportunity will begin to lay the groundwork for widespread communication with the state's doctors about these services.

***//2009// As with HSCI # 2, ascertainment of periodic screen information has improved. This can be seen from the consistent data reported for 2006 and 2007. A detailed explanation given for HSCI # 2 applies to this indicator also. A new Project LAUNCH application envisions working with the Assuring Better Child Development initiative (statewide spread using the Ages and Stages Questionnaire for child development assessment) to extend the effort to include the Socio-Emotional Scale. //2009//***

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	80.8	80.0	79.0	79.1	81.1
Numerator	30162	30353	30755	31697	33418
Denominator	37338	37956	38937	40061	41228
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2006**

The small, but very persistent trend for this indicator to get worse is of concern to the MCH folks and the ADH Director. It is consistent with a small but steady and persistent trend to see fewer pregnant women in our Local Health Unit prenatal clinics. The apparent changes are quite uniform among the regions in the state, so we believe they are a consequence of something pretty widespread in our socio-economic environment. As we prepare for the coming 5-year needs assessment, this issue will be discussed with our stakeholders to determine how best to address it.

**Narrative:**

The Kotelchuck Index uses three fields from the birth record of each baby: the date of the last menstrual period, the number of prenatal visits (and when they started), and the date of birth. It attempts to measure the amount of prenatal care the mother received recognizing that for a premature baby (for example, one born before 37 weeks) the mother could not have had the last weekly visits for weeks 37, 38, 39 and 40. The index calculates the number of visits reported on the birth certificate as a percentage of the visits expected for the length of gestation. Thus an index of 80% means that the mother had 8 visits if her pregnancy lasted long enough to cause an expected 10 visits. The expected visit number is taken from the ACOG recommended schedule of visits to occur each month for the first 7 months (to 28 weeks), then every two weeks through the 36th week, then every week until delivery. The number above represents the average Kotelchuck Index for all births in Arkansas. Note that among all births, the Kotelchuck Index score is declining slightly but very steadily. It is not yet clear what this trend indicates. At this writing, we have not looked at the trend by race. However, we have noticed that the numbers of women served in our local health units has been flat, or shown a very slight decline.

//2008// The Arkansas Department of Health continues efforts to improve the health of mothers and babies. ADH's role is to ensure all women in Arkansas have access to adequate prenatal care. Local health units in 57 counties provide prenatal services. The county health units work with the other health care providers in the community to ensure pregnant women have access to early prenatal care. Clients are provided referral information and accessibility to other ADH services, such as WIC and Immunizations. Designated Local Health Units determine presumptive eligibility (PE) of pregnant women for limited Medicaid benefits for outpatient prenatal care. Arkansas Medicaid can be granted for women up to 200% of the federal poverty level. Arkansas Medicaid also provides coverage for undocumented pregnant women under SCHIP (State Children Health Insurance Program). This is known as the "unborn child" provision. Births to Hispanic women number about 3300 in Arkansas each year.//2008//

//2008// A strong effort has been made to recruit and retain nursing staff to fill the shortages in the local health units. Colleague orientation to ADH programs provides new nurses a greater understanding and improved abilities in the Maternity Program.//2008//

//2008//The Campaign for Healthier Babies provides a coupon book designed as an incentive for pregnant women to obtain and continue prenatal care. Advertising efforts include media (radio and television and web sites), promotional flyers in doctors offices and public health units and a 24 hour telephone access help line. The Campaign provides for Medicaid participant outreach and education to facilitate enrollment, primary care physician selection and use of preventative services. On a cumulative basis, over 220,000 Arkansas Women have used the Happy Birthday Baby Book to help them have a better pregnancy. The HBBB was updated this year. //2008//

***//2009// The Center for Local Public Health has made vigorous efforts, with the support of the Women's Health Section, to increase its services to pregnant women. The ADH quality assurance review system tracks numbers of maternity patients served to monitor productivity. A small dip in numbers served in the last year was of concern, which has since reversed. The observed improvement in the Kotelchuck Index statistics reported above for this latest year is encouraging in the light of that effort. More emphasis is being placed on the use of reminder and recall systems in women's health, especially Family Planning. The Regional Director's Office in each of the five Public Health Regions has paid especial attention to productivity of staff in maternity clinics.//2009//***

***//2009// Governor Beebe has expressed an interest in reducing both teen pregnancy and infant mortality. The Center for Local Public Health and the Family Health Branch have collaborated in proposing a variety of community based special project ideas. These center mainly around enhancing clinical staff (circuit riding teams) to address gaps in capacity for family planning and prenatal clinics, and enhancing wraparound services***

*such as family planning care coordination, reminders and recalls, and community-based recruitment efforts.//2009//*

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	98.9	79.5	98.5	85.0	97.2
Numerator	361855	320430	450332	345512	464845
Denominator	365811	403245	457214	406494	478052
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2007**

2007 rate is percent of Medicaid enrollees who have received a service paid for by the Medicaid Program.

**Notes - 2006**

As MCH Director, I am not sure why these data are inconsistent. We are working more closely with our Medicaid partners to sort this out.

**Notes - 2005**

This data is the number of children under age 21 in any Medicaid Aid category during FFY 05. Data also includes the number of children under age 21 in any Medicaid Aid category with medical services incurred in FFY 05.

**Narrative:**

As with other indicators from Medicaid claims information, ADH staff do not have a "clear line of sight" into the way in which this data is collected, and why it might vary as it apparently does from the above numbers. However, conversations with data managers from EDS, Medicaid's data contractor, have strengthened in the last year, and we hope to have more detailed understandings in the near future. Also, as reported for other indicators, Arkansas is going to attend the ABCD technical assistance workshop to begin a statewide plan regarding ways to enhance services to children for routine periodic care, preventive services, and developmental assessments.

*//2009// The 2007 data presented above, as with other Medicaid counts of services appearing in this '09 application, shows increases in number served consistent with increases in enrollment. The 97.2 percent of enrolled children served is now more consistent with measures from 2003 and 2005. We believe that this data is better ascertained and reported from Medicaid files, and are reassured that enrolled children are actually seeing their primary care physicians. The Connect Care effort, contracted to the ADH and residing in the Health Connections Section of Family Health, has increased its efficiency in contacting new enrollees and setting up initial appointments with primary care physicians. The added "case management" active attempts to get newly enrolled*

*children an appointment with a dentist are going well, and may be helping to add completeness to enrolling children with physicians. Medicaid is joining with multi-agency state planners through the Early Childhood Comprehensive Systems collaborative and in so doing has paid greater attention to physician practices in the service of low income children. Children in both the "EPSDT level" and "SCHIP level" of Medicaid services benefit from these efforts. //2009//*

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	39.4	41.0	42.7	43.6	46.5
Numerator	26134	30827	38842	34517	37557
Denominator	66357	75151	90958	79094	80681
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2006**

Fewer providers were accepting Medicaid in FY 2006.

Arkansas is working on this problem in several ways:

- 1) The Oral Health Program conducts a public and professional awareness campaign every year. The Program also involves dentists in performing oral examinations on third grade children.
- 2) The Children's Medical Services staff work hard with their families to get more dental services for their enrolled children.
- 3) The Health Connections Section is now providing case management for new AR Kids First (and other) clients to get them appointed to a dentist's office as a new client. This effort is now just getting mounted, so when 2007 data are obtained, we should see some impact there.

**Narrative:**

The data above express the trend toward increased dental services among EPSDT (Medicaid, AR Kids A) children. A great deal of effort has gone into improving this trend. In the last few years, Medicaid has again increased fees to dentists, Dr. Lynn Mouden of the ADH has actively developed the oral health program in the state, and he has involved more and more dentists in voluntary efforts to screen third grade children for dental sealants and other evidence of care. The Oral Health Program conducts a Governor's Summit every summer which attracts a large attendance of dentists, dental hygienists, and other health professionals. In addition, Dr Mouden has visited many communities to urge the fluoridation of water supplies. There are many communities in Arkansas whose water still lacks fluoride, and the opposition to this change has been vocal. That fluoridation of public water supplies has, time and again, been proven safe, effective, and inexpensive, seems not to deter this opposition. Also, the Health Connections Section of the Family Health Branch has, under a new contract with Medicaid, added staff to help new Medicaid enrollees, both women and children, get first visits with a dental provider. Much oral health information is available through the Connect Care Hotline operated in the Health

Connections Section. Probably most effective, however, has been the Oral Health partnership with Children's Medical Services and with Head Start Programs where children are strongly encouraged to receive dental care, and where insurance resources can be sought out to cover these low income kids.

**//2009// The added efforts of the Health Connections Section, as supported through a contract from Medicaid, continue to build. Health Connections Staff contact parents of newly eligible children in AR Kids A (Medicaid) and AR Kids B (SCHIP), identify a nearby dentist and arrange appointments for the child. Then the staff person follows up to see that the visit occurred. Reminders and recalls are applied. The increase from 43.6 to 46.5 percent of children receiving dental services is encouraging. //2009//**

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	41.4	43.2	40.5	44.7	51.1
Numerator	5524	7411	7427	8658	10066
Denominator	13352	17155	18344	19382	19714
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

2007 data: renewal of relationships with families of CSHCN covered by SSI has led to an increase in this indicator in the past 2 years.

**Notes - 2006**

SSI Beneficiaries have among them a number of children who need rehabilitation services and are cared for by Children's Medical Services. One way to increase the percentage of children in need receiving those services is the availability of case managers for the CSHCN population. With reorganization of the CMS Program into the Division of Developmental Disabilities' Services, and attention from the Director of that Division allowing CSHCN case managers more time to follow these children, we may see some increase in this measure. 2006 information seems to support that supposition.

**Narrative:**

A slight increase in the numerator and the annual indicator is the result of services provided to applicants for the Title V Family Support/Respite program, a large number of whom were previously not known to the CSHCN program.

**Health Systems Capacity Indicator 05A:** *Percent of low birth weight (< 2,500 grams)*

<b>INDICATOR #05</b>	<b>YEAR</b>	<b>DATA SOURCE</b>	<b>POPULATION</b>
----------------------	-------------	--------------------	-------------------

<b>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>			<b>MEDICAID</b>	<b>NON-MEDICAID</b>	<b>ALL</b>
Percent of low birth weight (< 2,500 grams)	2006	matching data files	9.9	7	8.6

**Notes - 2009**

Data source: Provisional 2006 linked birth certificate / Hospital Discharge Data System records.

**Narrative:**

LBW is one of the leading risk factors for infant mortality and morbidity and continues to require additional effort to address. Nationally, LBW accounts for 60% of all infant mortality. Overall, the rate of LBW in AR for 2004 was 9.3%, over one percent higher than the national average level. The HP2010 Objective (16-10a) is to reduce LBW rate to 5.0%. Evidence suggests an association between low birth weight and prenatal care, especially first trimester care that continues until delivery. Women in high-risk categories often do not seek early prenatal care. Early prenatal care for low-income women is dependent on availability, accessibility and affordability. March of Dimes data reported during 2001-2003 (average), about 1 in 5 women of childbearing age in Arkansas were living in families with incomes below the Federal Poverty Level. One in 4 women of childbearing age are uninsured. The proportion of women in poverty and uninsured women are significantly higher than the national average level.

//2008// Comparing the above percentages to what was reported in this application for 2003, the Medicaid low birth weight rate increased from 9.7 to 10.0, while the non-Medicaid low birth weight rate decreased from 7 to 6.7. The rate for "all" births increased from 8.3 to 8.6 because 55% of all births in Arkansas are paid by Medicaid, so the total tracks with that population. While the rate difference for these two subgroups is not startlingly different for the compared years, and may just be year-to-year variation, these trends are in accord with rising national trends in low birth weight rates for African American babies, while those for Caucasian babies have declined. This evidence of increasing disparities is of concern, especially because of the great efforts to correct these trends through Medicaid expansions of eligibility. Those expansions included 1) pregnant women to 200% of poverty accomplished several years ago, 2) infants to 200% of poverty accomplished with the development of AR Kids First including SCHIP for infants, and 3) the inclusion of immigrant mothers in prenatal coverage through the "unborn child provision" in the Medicaid State Plan. The State's rates for early and complete prenatal care have also gradually slipped since regular increases peaked about two years ago.

//2008// An interesting contrast of data is beginning to appear. The total percentage of children in poverty appears to be declining in Arkansas. So does the total percentage of children without health insurance. Additionally, teen birth rates are declining. One would expect that these changes would "place downward pressure" on low birth weight, preterm, and infant mortality rates. The total percentages, however, tend to hide what is happening to the lowest socio-economic subgroup. When African American births are looked at, the disparities in low birth weight, preterm birth and infant mortality are widening. Although the explanation for these findings is not yet clear, one wonders if life situations linked mostly to African American citizens, that are additional to poverty (cultural), are at work. For public awareness, patient education, and community based activities to be enhanced, health care leaders should be increasingly attending to cultural awareness in the provision of these services.

//2008// The Campaign for Healthier Babies continues to provide a coupon book designed as an incentive for pregnant women to obtain and continue prenatal care. Over the years since initiation of the service, over 220,000 Arkansas Women have used the Happy Birthday Baby Book to help them have a better pregnancy. ADH maintains a resource referral directory, available by a toll

free number, to provide information for the public, providers and the local health units. The Health Connections Section of the Family Health Branch, operates a hotline to support the Healthier Baby public health spots, and allow a place for a pregnant woman to obtain the Happy Birthday Baby Book (containing health information), as well as names of doctors and other providers of services relevant to pregnancy and childbirth.//2008//

**//2009// All the above efforts continue. The trend on teen birth rates has ceased its decline, and it appears that LBW trends are continuing upward. Arkansas is concerned about these indicators. Arkansas's new Governor, Mike Beebe is interested in teen pregnancy and infant mortality and has asked ADH to propose some new special projects. A variety of types of activities have been discussed within ADH, particularly between the Family Health Branch and the Center for Local Public Health. Most of these ideas center around several community-based projects aiming to build clinic capacity where needed, and to add care coordination and outreach to support family planning and prenatal clinics. (See comments under HSCI # 04.) //2009//**

#### **Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births**

<b>INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>	<b>YEAR</b>	<b>DATA SOURCE</b>	<b>POPULATION</b>		
			<b>MEDICAID</b>	<b>NON- MEDICAID</b>	<b>ALL</b>
Infant deaths per 1,000 live births	2006	matching data files	9.8	7.7	8.8

#### **Notes - 2009**

Data source: Provisional 2006 linked birth certificate / Hospital Discharge Data System records.

#### **Narrative:**

The Arkansas Medicaid Program pays for the birth hospitalizations of 55% of all babies born in the state. Though a majority, they contain, by financial eligibility rules, nearly all births to low income families in the state, and as such, have higher concentrations of minority and immigrant births. Thus it is not surprising that infant mortality rates are higher in Medicaid. The data presented above are taken from linked birth/infant death files which in turn are matched to Medicaid records. This special study file shows the death rate for "all" births at 7.1. This represents a decline from 7.3 as reported on Form 18 for 2003. However when the individual birth groups are examined, the Medicaid rate went from 7.8 in 2003 to 8.2 in 2005, while the non-Medicaid group went from 6.6 to 5.3. While these differences may not be alarming because of year-to-year variations in these rates, this finding is consistent with trends in race-specific infant mortality rates in which the African American to Caucasian infant mortality ratio has been increasing. Significant and steady increases in low birth weight rates, and in preterm births, observed in both Arkansas and the US, which are also increasing in disparity, lies behind this trend. These changes are broad-based in cause (not just due to Assisted Reproductive Technology) because even singleton live births are increasing in these risk factors. That infant mortality, over all, has not risen, probably speaks to the efforts over the last few year to get more mothers covered with Medicaid (increasing eligibility to 200% poverty and the implementation of the 'unborn child' provision in SCHIP), and to assure that unwanted pregnancies are prevented as reliably as possible (Family Planning Waiver). It may also be due in part to the decline in teen births both as a fraction of all births, and in teen birth rate. Increases in eligibility for all children up to 18, includes teenagers in its positive impacts, also leading to increased care for pregnant teens. Finally, review of ANGELS evaluation data shows that birth weight specific infant mortality rates at under 1500 grams and under 1000 grams continue to improve.

//2009// Concern about continuing high rates of low birth weight go on apace. The discussion above still applies. The program is expecting, when final infant death data become available, (perhaps before this application is submitted) that Arkansas may see a rise in infant death rate. If that happens, ADH will take a detailed look at all the risk factors related to infant death to determine the most appropriate actions to address the problem.//2009//

//2009// As part of the ANGELS evaluation, Dr. Kande Ananth, an epidemiologist from New Jersey, has pointed out that Infant death rates among Arkansas Medicaid births who are late preterm and have birth weights in the 2000 to 2500 gram range are disproportionately higher compared to non-Medicaid births in the same weight range; while other birth weight ranges show more comparability between Medicaid and non-Medicaid births. To date this finding has not had a lot of discussion neither in Arkansas, nor in the national literature. Arkansas's interpretation is that the very low birthweight babies suffer from medical complications that are serious enough to outweigh the effects of socioeconomic disparities, and are well served by perinatal intensive care. Thus in the higher birth weight categories the S-E disparities are more evident. The thought offers another avenue of effort to address the disparities issue - community based, culturally sensitive, special projects to enhance capacity of prenatal and family planning services, and enrich them with wraparound services such as care coordination and recruitment. (See discussions in HSCI #s %A and 4.) //2009//

//2009// Dr. Nugent reviewed infant mortality data for Arkansas, presented it at ADH Grand Rounds last spring, and, last summer, presented to a retreat of County Health Officers, attended by well over half of those physicians who serve as "County Health Officers". During that presentation he emphasized Prematurity, Birth Defects and SIDS. Interventions cited as worthy of consideration included preconceptional health for young women, folic acid tablets as dietary supplementation to prevent neural tube defects, and Back-to-Sleep campaigns in communities with high minority populations where stomach-lying is still the rule rather than the exception. All of these interventions would profit from the development within ADH of social marketing capabilities, and funds to contract with community entities to enhance local planning and activities. Subsequent discussions of potential new projects within ADH have also taken this perspective into account. (See discussions under HSCI #s 05A and 4.)//2009//

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	71	88.5	78.7

**Notes - 2009**

Data source: Provisional 2006 linked birth certificate / Hospital Discharge Data System records.

Indicator for "All" differs from National Performance Measure 18, "Percent of infants born to

pregnant women receiving prenatal care beginning in the first trimester" due to different data source.

**Narrative:**

Additional to the above, data for women seeking prenatal care with their local public health units for CY2006 found 55% (2782/5009) initiated prenatal care during their first trimester. However, 9.5% (480/5009) of pregnant women seen at the local health units waited until their third trimester to begin prenatal care. This information again reflects differences between those who use the public health system and those who are able to access private care.

//2008//The information given above, showing 79.8 percent of births with prenatal care beginning in the first trimester, is down slightly from 80.4% reported for 2003 in a prior application. These two data points are comparable in trend to that among all birth certificates. In the unmatched data trend presented in National Performance Measure 18, the trend is slightly but steadily down over the years of 2003 to 2006. Returning to the above information, the Medicaid births show an early prenatal care rate of only 72% in 2005, down slightly from 72.2% in 2003, while non-Medicaid births show a rise from 87.7% to 89.8% in 2005. Again, we see trends that lead toward greater disparity, not less. So far, prenatal care, low birthweight, and infant mortality are all showing widening disparities, despite programmatic efforts to head off these trends.//2008//

**//2009// Please see comments shared for previous HSC indicators. The indicator for first trimester care seems better, but LBW and IMR trends continue to be worrisome. //2009//**

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	71.1	79.3	74.7

**Notes - 2009**

Data source: Provisional 2006 linked birth certificate / Hospital Discharge Data System records.

Indicator for "All" differs from Health Systems Capacity Indicator 04, "Percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck index" due to different data source.

**Narrative:**

The Kotelchuck Index uses three data fields from birth certificates: last menstrual period date, number of prenatal visits, and the date of birth. It then compares the number of reported visits in relationship to the number of visits the mother could have attended according to the length of her pregnancy. The Index attempts to control for the fact that mothers who deliver at or before 36 weeks (for example) could not have had the last 4 expected prenatal visits. So a Kotelchuck

index of 80% means that the mother actually received (according to birth certificate data which has some limitations here) 80% of the visits she could have been expected to receive, given her date of delivery. It also creates categories of "inadequate care," "intermediate care" "adequate care," and an extra care category which is taken to mean that the mother had many more visits than expected, probably because she had a medical complication of pregnancy requiring the extra visits.

//2008//Note that again, the Medicaid births show a lower average Kotelchuck Index score than non-Medicaid. Compared carefully to low birth weight and infant mortality, this difference is not so striking. The reason is that the effect of preterm birth has been controlled in the Index comparison. None-the-less, comparing these data points to 2003 data, the Medicaid Kotelchuck score of 70.7% in 2005 represents a decline from 73.8 in 2003, while the non-Medicaid Kotelchuck score of 76.5% in 2005 represents a very slight decline from 77.5% in 2003. Again, these differences are not large, but they are not moving in a favorable direction.//2008//

***//2009// Comparing the above Kotelchuck Index data for 2005 to 2006, the Medicaid Index of 70.7% has increased to 71.1, and the non-Medicaid Index of 76.5% has improved to 79.3. Again these favorable measures are encouraging. Still the increase for non-Medicaid births is more rapid than that for low income mothers, indicating a continuing widening of disparities. //2009//***

**Health Systems Capacity Indicator 06A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)**

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2007	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2007	200

**Narrative:**

Indicator 06 states the income level for financial eligibility for infants and pregnant women in the Arkansas State Medicaid Plan stands at 200% of poverty, a provision of the AR Kids First insurance program serving the large majority of low income pregnant women and infants. The same eligibility level exists in Medicaid for infants enrolled to be served with SCHIP funds. Eligibility increases to these levels have now existed for several years.

Using other information, insurance coverage data obtained from the ADH encounter management data (CY2006) reported 1.8% of women with a maternity code had private insurance coverage with 78.5% (8,721) under public insurance coverage, 14% (1605) were uninsured, and a remaining 5% (570) with unknown coverage. It is a practice of local health units to refer women with positive pregnancy tests to private doctors in the community if they have private insurance covering obstetrics. This conserves public clinic capacities for those not so fortunate, and enables a more collaborative relationship with private physicians. It is also notable that among a group of women, selected out by the system of care as very likely to be low income, only 14% were uninsured. This suggests that Medicaid expansions have had positive effects in reducing the "gap group" of pregnant women and their infants.

***//2009// Income eligibility policy in Medicaid has not changed. A recent discussion in the General Assembly questioning the legality of providing services to illegal aliens has not resulted in much programmatic change. A new planning effort is now being discussed***

*with regard to increasing Medicaid eligibility for children to the 300% poverty level. So far resources have not been available that would make it feasible to implement such a plan in the near future.//2009//*

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 18)	2007	200 200 200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 18)	2007	200 200 200

**Narrative:**

This data indicates in more detail the State Medicaid Plan's provisions for low income pregnant women and children. The AR Kids A and B programs (A is made up mostly of Medicaid children and B is made up mostly of SCHIP children) have implemented these eligibility levels. Using 2003 data for AR Kids A and B enrollment, and US Census 2000 data to estimate the number of Arkansas children in families below 200% of poverty provided an estimate of 83% of all estimated eligible children were enrolled. That estimate was regarded as reasonably accurate, and a favorable rate of enrollment.

Current Population Survey data indicate that the estimated percentage of children in poverty in Arkansas has decreased over recent years as follows: 31.2% in 2002, 26.8% in 2003, 25.8% in 2004 and 24.9% in 2005. Parallel to this trend are declines in percentages of children who are uninsured as follows: 51.6% in the combined data years of 2001-2003 (a three-year moving average), to 49.6% in 2002-2004, to 47.6 in 2004-2005. Three year moving averages are used to "smooth out" the variability from year to year so the underlying trend is made visible.

Thus, two favorable trends are occurring simultaneously, there are fewer low income children, and fewer of them are uninsured. At this writing we do not have this data by race. Such information might help us to answer the question why this positive information should exist alongside increasing disparities for prenatal care, low birth weight, and infant mortality rates.

*//2009// Income eligibility for children still stands at 200% of poverty. There is some talk about raising it to 300% poverty, but resources have not been made available that would make such a change likely.//2009//*

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
---	-------------	--

<b>pregnant women.</b>		
Pregnant Women	2007	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2007	200

**Narrative:**

The information above states in more detail the provisions of the Arkansas State Medicaid Plan for financial eligibility for enrollment in Medicaid and SCHIP programs. In Arkansas, AR Kids A is made up mostly of Medicaid-enrolled children, and AR Kids B has a higher proportion of children enrolled in SCHIP. Medicaid for Pregnant women provides an eligibility level of up to 200% of poverty, while the "unborn child provision" program serving immigrant pregnant women also serves women to 200% of poverty.

Insurance coverage data obtained from the ADH encounter management data (CY2006) reported 1.8% of women with a maternity code had private insurance coverage with 78.5% (8,721) under public insurance coverage, 14% (1605) were uninsured, and a remaining 5% (570) with unknown coverage.

March of Dimes data reported during 2001-2003 (average), about 1 in 5 women of childbearing age in Arkansas were living in families with incomes below the Federal Poverty Level. 1 in 4 women of childbearing age are uninsured.

The proportion of women in poverty and uninsured women are significantly higher than the national average level.

*//2009// Changes in poverty level eligibility in the Medicaid for Pregnant women program seems unlikely to occur this calendar year. However, the Arkansas General Assembly convenes again in January 2009, and the issue may arise then. //2009//*

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<b>ANNUAL DATA LINKAGES</b>		
Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
	3	Yes

Annual linkage of birth certificates and newborn screening files		
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

#### **Notes - 2009**

##### **Narrative:**

The only "No" answer on this table relates to birth defects surveillance. While the ADH Center for Health Statistics, now called the Health Statistics Branch, does not have direct access to this data, there is a very sophisticated data sharing agreement between Health Statistics and the Birth Defects Surveillance and Research Program at Arkansas Children's Hospital. Linked birth/infant death data from ADH are matched to clinical birth defects data from Arkansas Children's Hospital, the identifiers are removed, and a research file is created for both agencies to use in their reporting. This collaboration has provided statistical information for a very strong birth defects surveillance program in Arkansas, recognized by CDC as one of the best in the nation.

***//2009// The Center for Birth Defects Surveillance and Research continues its exemplary progress. Recently, Dr. Charlotte Hobbs shared very new data that scientific evidence was beginning to show a correlation between maternal obesity and certain structural birth defects. The Center continues to alert Arkansans to the fact that use of folate supplementation by women in the state continues to lag. //2009//***

Arkansas is fortunate to have very high quality databases for births, infant deaths, fetal deaths, and hospital discharges. The same is true for programmatic databases for newborn hearing screening, newborn metabolic screening, cancer registries, STI data files, and many others. Also, PRAMS, BRFSS and Tobacco survey data programs are very strong in this state. While YRBS data for the statewide sample are gathered by the Department of Education in selected school districts, the Hometown Health Improvement Coalitions in many counties have stimulated their school districts to perform their own. The Center for Health Statistics has provided the statistical and survey support to school districts wanting to do this, and has accumulated a good deal of local information on certain counties from time to time.

***//2009// The ADH Health Statistics Branch (HSB) (formerly the Center for Health Statistics) located in the Center for Health Practice, continues to work very effectively with the evaluation efforts of the Antenatal and Neonatal Guidelines for Education and Learning Systems (ANGELS) program. The Health Statistics Branch (HSB), receiving "pregnancy episodes" gleaned from Medicaid claims data by the evaluators, have been able to match up to 94% of those episodes to linked birth/infant death records, and additionally to hospital discharge records. The linkage has been achieved for a 24-month period prior to the start of ANGELS, and a 30 month period after the start of ANGELS. Detailed analyses of these data are now being conducted and publications planned. An initial methodology paper will be published soon in the MCH Journal. //2009//***

***//2009// The HSB, with considerable contributions from the ADH MCH Epidemiologist,***

***provided the necessary data and consultation on trend interpretations for the Infant Mortality presentation given by Dr. Nugent to ADH Grand Rounds last spring. //2009//***

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	3	No

**Notes - 2009**

Although the MCH program does not have direct access to state level YRBS data, the program does have access to periodically administered county-based YRBS data for analysis.

**Narrative:**

See comments from the previous Health Systems Capacity Indicator regarding other statistical capabilities, wherein the ADH Center for Health Statistics (now the Health Statistics Branch of the Center for Health Practice) has access to statistics obtained by individual school districts that they support.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

#### **1. Introduction**

The MCH Block Grant Planning Team, in the light of the recommendations from the Stakeholders' group and the trends seen in the Performance Measures, decided to continue with all state priorities followed in the past, and to add one more State Performance Measure. The tenth priority is devoted to measuring BMI in Family Planning patients, provide education and written materials to clients, and make referrals to community sources of support for healthy lifestyles with respect to nutrition and physical exercise. Within state priorities devoted to Pregnant Women and Infants, Children, and Children with Special Health Care Needs, new activities will be added to implement the four new partnerships recommended by the Stakeholders.

#### **2. The MCH Planning Team selected the following priorities:**

- a. To reduce the percentage of women smoking during pregnancy
- b. To reduce the percentage of high school students engaging in sexual intercourse
- c. To increase the percentage of children 0-18 and below 200% of poverty who are enrolled in the AR Kids First Program
- d. To increase the percentage of pregnant women counseled for HIV testing
- e. To reduce the percentage of children who are overweight among WIC children 0-5 years of age.
- f. To increase the percentage of 14 and 15 year olds on CMS who state that CMS transition services have helped improve their knowledge/ability to transition to adult life
- g. To increase the percentage of parents responding on the CMS Parent Satisfaction Survey that CMS service coordination teams told them about other services available to them
- h. To reduce the percentage of public school students who are overweight (greater than the 95th percentile of weight for height)
- i. To reduce the percentage of public school students at risk for overweight (85th to 95th percentile of weight for height)
- j. New: To increase the percentage of Family Planning clients with BMI greater than the 85th percentile who receive educational materials in the Family Planning clinics, and are referred to community sources of counseling and support.

The primary change in the priorities listing was to add a new priority as listed in j. above.

The process to determine the priority needs began with a thorough review of data elements relative to a wide range of health issues relevant to women and children. Organizers of the Needs Assessment effort established the MCH Planning Team, made up of leaders from Family Health including the Perinatal Health and Reproductive Health Programs in Women's Health Work Unit, the Child and Adolescent Health Work Unit, the Oral Health Work Unit, the WIC Work Unit and the Children's Medical Services Program of the Department of Human Services. The Planning Team then organized a group of external Stakeholders to obtain input from a wide range of community, university, academic and state agency leaders to share their priorities.

The partnership building effort began with the formation of the Stakeholders' group. The Stakeholders developed a list of 14 priority issues of importance to women and children presented in the following list:

- a. Obesity, nutrition and physical activity
- b. Access to care, especially for prenatal care, routine child care, and CYSHCN
- c. Smoking and tobacco use
- d. Chronic diseases, especially obesity, diabetes, hypertension, cancer and heart disease
- e. Needs for health education and behavior change, especially public awareness and marketing,

sexuality and early prenatal care

- f. Communicable diseases, especially HIV, STDs, Immunization-preventable illness
- g. Need to address health system complexity through care coordination and family-centered approaches such as the medical home
- h. Need to improve child health screening programs and care coordination, Especially EPSDT, Newborn screening and AR Kids First as a way to support preventive services
- i. Mental health, suicide, depression and chronic stress
- j. Application of distance communications technology -- telemedicine, distance learning, knowledge management, consultation and referrals
- k. Oral health for all children, but especially for pregnant women and CYSHCN
- l. Domestic violence prevention
- m. Injury prevention
- n. Substance abuse treatment and prevention including alcohol.

As the Planning Team reviewed the national priorities and chose the state priorities, the above list was considered.

- a. Pregnant women and infants
- b. Children's services and systems of care
- c. Children and youth with special health care needs, and
- d. Women

Four planning partnerships are envisioned in Priority j. in Section 2.

The MCH Planning Team considered these priorities and recommendations in completing the needs assessment. They recognized that many of the themes of interest presented in the Stakeholders' priority list were already being addressed through priorities that existed in the national performance measures, especially the access to care issues for pregnant women, children and children with special health care needs.

//2007//Priorities have not changed, however the configuration of planned partnerships has changed, as they have developed. While the Pregnancy and Infant Partnership has remained the same (ANGELS - Medicaid, UAMS and ADH), the child health partnerships activities are new. For Primary and Preventive Health Services for Children, the Division of Health is working closely with the Division of Child Care and Early Childhood Education, as well as the Division of Developmental Disabilities Services (the Children's Medical Services [CSHCN] Program is in this Division and is also involved) in the Arkansas Early Childhood Comprehensive Systems partnership. Significant strides have been made toward the development of a "tiered quality of service" system for Arkansas. Recommendations for five "tiers" have been developed and accepted. The DDS of DHS and ADH are also working together on a statewide initiative for Child Mental Health Services. The ADH partnership with Community Health Centers is taking the form of increased referral of Family Planning patients with chronic diseases, and now obesity to CHCs for followup care. //2007//

//2008// Priorities have not changed. Major strides are being made in partnerships with UAMS OB/GYN (ANGELS), DHS Division of Mental Health (System of Care), DHS Division of Child Care and Early Childhood Education (Early Childhood Education Quality Rating System, and with The Department of Education (Coordinated School Health). BMI measurement and provision of counseling for nutrition and weight control are advancing. The method of measuring the success of efforts to educate family planning patients about obesity and high BMI has changed to accommodate available data.//2008//

***//2009// Partnerships have rapidly developed. System of Care for Children's Mental Health - During the 2008 session the AR General Assembly, influenced by a many-page list of agencies in the SOC partnership, passed legislation providing the principles for the planning and development of a statewide infrastructure to build a system of care for***

*children's mental health. Funding was also made available to provide incentives for the development of community services for children's mental health. The Children's Behavioral Health Commission, established by the legislation, met in June, 2008. The Department of Human Services and its Division of Behavioral Health presented an implementation plan to the Commission which voted to recommend the plan for approval by DHS. That plan provided for a Request for Proposal Process to fund at least two community projects to initiate system development at the local level. Meanwhile, collaborative efforts of all related divisions and departments have gained momentum. The Commission felt that much more progress should be made to develop collaborative efforts with the Department of Education. State agencies agreed to form workgroup for that purpose. //2009//*

*//2009// Other Partnerships are discussed in Part B of this State Narrative. //2009//*

## **B. State Priorities**

The MCH Planning Team selected the following State Priorities:

- To reduce the percentage of women smoking during pregnancy

Working with the ANGELS project, new screening tools for smoking assessment are being developed that will be incorporated into maternity clinic services in the state.

- To reduce the percentage of high school students engaging in sexual intercourse.

Abstinence Education and Unwed Birth Prevention programs continue to fund special project grants in selected communities to reduce adolescent sexual activities. The selection process for these grant programs favors larger cities with the intent of impacting on the state rates as much as possible.

- To increase the percentage of children 0-18 and below 200% of poverty who are enrolled in the AR Kids First Program

The State Medicaid Program continues to prioritize enrolling eligible children in the AR Kids A and B programs, and Local Health Units, when they identify children from low-income families in WIC and Immunization clinics continue to make referrals to local Human Services County Offices.

- To increase the percentage of pregnant women counseled for HIV testing.

Local Health Unit prenatal clinics continue to counsel prenatal patients about the need for HIV testing, and offer the test.

- To reduce the percentage of children who are overweight among WIC children 0-5 years of age.

The Healthy Arkansas Initiative, supported by the Governor and state health and education agencies is prioritizing the identification of overweight and at risk for overweight children in schools and other places, and developing community support for counselling and other follow-up. The WIC Program continues to measure heights and weights, to calculate percentiles of height for weight, to give nutritional advice to children at risk, and to refer to community sources of support.

- To increase the percentage of 14 and 15 year olds on CMS who state that CMS transition services have helped improve their knowledge/ability to transition to adult life

The CSHCN Program continues to emphasize its educational and case management services for

14 and 15 year old services with the emphasis on educating about transitional issues and services.

- To increase the percentage of parents responding on the CMS Parent Satisfaction Survey that CMS service coordination teams told them about other services available to them

- To reduce the percentage of public school students who are overweight (greater than the 95th percentile of weight for height)

At the beginning of school this fall, all schools will be again measuring heights and weights, and informing parents of children who are at risk for overweight or overweight. Major activities in schools to improve the nutritional value of foods available through food services are under way. The Child Advisory Committee, established through Act 1220 has made major recommendations to the Governor and to the Board of Education and Health regarding new rules to be adopted by the Board of Education. Work on these new rules should culminate in the next few months.

- To reduce the percentage of public school students at risk for overweight (85th to 95th percentile of weight for height) (see above)

- New: To increase the percentage of Family Planning clients with BMI greater than the 85th percentile who receive educational materials in the Family Planning clinics, and are referred to community sources of counseling and support.

The primary change in the priorities listing was to add a new priority as listed in j. of Section 2.

The MCH Planning Team, in completing the requirements for national performance measures and state performance measures are thereby responding to the Stakeholders' interests as follows

- Obesity, nutrition and physical activity

This Stakeholder priority is addressed in National Performance Measure 10 (Breastfeeding), State Performance Measures 27 (WIC children over 95th percentile weight for height), 30 (students over 95th percentile) and 31 (students at risk for overweight).

- Access to care, especially for prenatal care, routine child care, and CYSHCN

This Stakeholder priority is addressed for pregnancy in National Performance Indicator 18 (Births with first trimester care); and for child care and CYSHCN in National Performance Measures 2-6 (CSHCN measures of availability of coordinated care), 13 (children without health insurance), and 14 (potentially eligible children receiving a service), and State Performance Measures 22 (Children <200% poverty enrolled in AR Kids A and B), and 29 (CSHCN children receiving coordinated services).

- Smoking and tobacco use

This Stakeholder priority is addressed in State Performance Measure 32 (women smoking in pregnancy).

- Chronic diseases, especially obesity, diabetes, hypertension, cancer and heart disease

This Stakeholder priority is addressed in a new State Performance Measure 33 (measuring body mass index in Family Planning clinics and providing patient education and referral)

- Needs for health education and behavior change, especially public awareness and marketing, sexuality and early prenatal care

This Stakeholder priority is addressed in National Performance Measures 8 (birth rate for adolescents) and 18 (first trimester prenatal care), and State Performance Measures 21 (students having sexual intercourse)

24 (HIV counseling and testing), 30 (overweight children in schools), and 31 (students at risk for overweight).

- Communicable diseases, especially HIV, STDs, Immunization-preventable illness

This Stakeholder priority is addressed in National Performance Measure 7 (immunization by age 2), and State Performance Measure 24 (pregnant women counseled and tested for HIV).

- Need to address health system complexity through care coordination and family-centered approaches such as the medical home

This Stakeholder priority is addressed in National Performance Measures 2-6 (CSHCN access to care measures), and State Performance Measures 28 (14 and 25 year olds receiving transitional education and referral), and 29 (parents receiving service coordination).

- Need to improve child health screening programs and care coordination, Especially EPSDT, Newborn screening and AR Kids First as a way to support preventive services

This Stakeholder priority is addressed in National Performance Measures 1 (newborn screening), 2-6 (CSHCN measures), 7 (immunizations), 9 (third graders with sealants), 10 (breastfeeding), 12 (newborn hearing screening), and 14 (potentially eligible children receiving services in Medicaid).

- Mental health, suicide, depression and chronic stress

This Stakeholder priority is addressed at the level of creating two new planning partnerships, one around children's services and systems of care, and one around children with special health care needs. The development of these two partnerships is addressed in several state performance measures.

- Application of distance communications technology -- telemedicine, distance learning, knowledge management, consultation and referrals

This Stakeholders priority is addressed in the formation of a partnership around pregnancy and infant health care and plans for its implementation appear in the State Performance Priority for smoking in pregnancy.

- Oral health for all children, but especially for pregnant women and CYSHCN

This Stakeholder priority is addressed in National Performance Measure 9 (Third graders and sealants)

- Domestic violence prevention

This Stakeholder priority will be addressed through the pregnancy and infant health partnership, and is being developed through the existing partnership with UAMS OBGYN department project ANGELS.

- Injury prevention

This Stakeholder priority is addressed in National Performance Measure 10 (motor vehicle death

rate for children).

- Substance abuse treatment and prevention including alcohol.

This Stakeholder priority will be addressed through the development of the partnership for children, and the partnership for women.

//2007// Priorities for MCH planning have not changed. However, the partnerships in which Title V staff are participating have developed considerably. The ANGELS partnership continues and is growing. The Child Health Partnership is working through three programmatic groups - Coordinated School Health Initiative, the Child Mental Health Initiative, and the Arkansas Early Childhood Health Comprehensive Systems planning and implementation efforts. The women's health partnership is forming around obesity identification in Family Planning Clinics, provision of educational information to those at risk, and working in communities to develop resources to aid these clients in better weight management. The Healthy Arkansas campaign is a community based effort to increase physical activity, eat healthy, and smoke less. //2007//

***//2009// While priorities have not changed for purposes of this grant, Arkansas has made strides in the development of Partnerships. The System of Care Partnership was discussed in the Background and Overview section of this narrative.***

***-Arkansas Early Childhood Comprehensive Systems (AECCS). Funded by the national ECCS program of MCH Bureau, and led by Martha Reeder of the Division of Child Care and Early Childhood Education (DCCECE), Arkansas began its collaborative efforts by developing a recommendation for a "tiered quality of service" system for Arkansas Early Childhood Education (ECE) providers. ADH, UAMS, and others worked closely on the health aspects of those guidelines. The recommendations were developed with the input of the state's association of early childhood education providers and adopted by the DCCECE which found funds to incentivize ECE providers to advance their services according to the guidelines. The first two tiers were targeted for implementation in the first year of implementation. The Early Childhood Commission closely followed the progress of the AECCS effort. Many details of this process are presented in project reports to the MCHB.***

***-Assuring Better Child Development (ABCD). Growing out of the AECCS Partnership, and coordinated by Martha Hiatt of DCCECE, Arkansas applied and was included in a national technical assistance effort called ABCD. Ms. Hiatt set up a Core Team, including Ms. JoAnn Bolick of the ADH Child and Adolescent Health Section of Family Health, and a Stakeholder's Committee including Dr. Richard Nugent. Arkansas Medicaid and the Arkansas Foundation for Medical Care (AFMC - the PRO organization) participated in critical aspects of this plan. A productive part of this effort, the Medical Subcommittee, convened to review national offerings for validated tools to screen for developmental disabilities. They recommended several tools, but preferred the Ages and Stages Questionnaire. The Committee purchased copies of the questionnaire and shared them with two private practices willing to pilot their use. Dr. Dennis Yelvington, a family physician in Stuttgart, and Dr. Chad Rogers, a pediatrician in Little Rock agreed to integrate the use of this tool into the staff duties in their offices. A significant aspect of this instrument is obtaining information directly from parents at the start of the assessment. Both practices have reported to the ABCD Stakeholders' Committee of success with applying the tool, and are now in the process of informing their statewide physician colleagues. Medicaid established special reimbursement codes so that these additional services received compensation. In addition, Medicaid, through a contract with AFMC, has provided technical assistance through direct and frequent visits to these pilot practices. AFMC and Medicaid have also developed relationships with as many as 50 other practices to become pilots to enhance EPSDT screening and preventive services. AECCS has now adopted a "statewide spread strategy" to extend the use of the ASQ or***

**other instruments to those practices. Staff of AFMC are able to visit these practices at least annually and more frequently where practice interest exists.**

**-National Center for Children in Poverty policy initiative (NCCP). Arkansas pursued a technical assistance process with the NCCP to develop policy for early childhood services. Also coordinated by Ms. Hiatt of DCCECE, this policy process incorporated all the partners of the System of Care for Child Mental Health (See Background and Overview), AECCS, and ABCD; Arkansas Advocates for Children and Families; representative of family practice and pediatrics; the State Primary Care Agency; and many other public and private entities interested in serving children. Guided by Ms. Kay Johnson, a nationally recognized technical assistant for policy development for children, the process resulted in a set of recommendations for both policy development and program enhancement. The group made a clear recommendation to Medicaid that it should require its primary care providers to perform developmental assessments by a validated tool. At that meeting the ADH expressed interest in enhancing services around the state for care coordination in the area of child health.**

**-Project LAUNCH (Links to Address Unmet Needs in Child Health). In May, ADH became aware of the opportunity to apply for a grant jointly sponsored by MCH Bureau and the Substance Abuse and Mental Health Services Agency (SAMHSA) called Project LAUNCH. Through a combined effort of the DHS Divisions of DCCECE and Behavioral Health, also involving Partners for Inclusive Communities of UAMS, and the ADH Child and Adolescent Health Section of Family Health, Arkansas submitted a proposal establishing a statewide Early Childhood Partnership Council made up of many of the partners participating in the above efforts. For its community-based effort, Dr. Dennis Yelvington of Stuttgart again stepped up, agreeing to add to his use of the Ages and Stages Questionnaire its component assessment for Socio-Emotional Development. Arkansas is likely to proceed with the formation of the Partnership Council, even if the application does not succeed.**

**-Newborn Screening (NBS) expansion. As of July 1st, Arkansas expanded its newborn screening program to include screening for all 29 nationally recommended conditions. Movement toward this expansion began with a White Paper from ADH, involving collaborators from the office of the Deputy Director, the Science Advisory Committee, the office of General Council, the State Laboratory, and the Family Health Branch, chiefly the Child and Adolescent Health Section. The White Paper recommendation to expand was adopted by the Board of Health initiating regulation which set the new fee at \$89.25 per specimen submitted, and provided for the participation of hospitals and insurance companies throughout the state. Arkansas had already been screening for 6 metabolic conditions and also newborn hearing screening, with major staff efforts to notify primary care physicians and families of abnormal results on initial screenings. Nevertheless, the addition of the 22 conditions, especially Cystic Fibrosis and Congenital Adrenal Hyperplasia required extensive and detailed collaboration between the ADH Lab and the CAH follow-up program, as well as critical technical assistance from the UAMS Department of Pediatrics' subspecialists (hematology, biochemical genetics, endocrinology, and pulmonary medicine) to produce protocols guiding the agencies and primary care physicians to respond appropriately to each of the conditions identified on initial screening. Follow-up not only by the ADH Child and Adolescent Health Section, but pediatric subspecialists, and particularly the specialty clinics at Arkansas Children's Hospital (ACH) was also included in the protocols being developed. Finally, ADH and the Arkansas Children's Hospital Laboratory made plans to deal appropriately with "first and second tier" studies for Cystic Fibrosis and Congenital Adrenal Hyperplasia. Preparations for the expansion included public and professional awareness campaigns conducted in June 2008 with the assistance of the ADH Public Information Office and similar offices of UAMS, ACH, St. Vincent's Hospital and the Baptist Health System.//2009//**

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	98	98	98	100	100
Annual Indicator	98.2	97.6	100.0	100.0	100.0
Numerator	54	41	44	46	33
Denominator	55	42	44	46	33
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

#### Notes - 2006

Information obtained from Newborn Screening Program.

#### Notes - 2005

Information obtained from Newborn Screening Program

#### a. Last Year's Accomplishments

NPM 01

On October 26th, 2006, the Arkansas Board of Health gave approval to move forward with plans for expansion of the State's newborn screening program. The Board's new regulations enabling the expansion were approved by the necessary legislative committees to expand the screening panel to include 29 "Core" Conditions, including Cystic Fibrosis, Congenital Adrenal Hyperplasia, Biotinidase, and conditions detected by tandem mass spectrometry. This expansion will align the Arkansas's newborn screening program with the current national recommendations. The cost of the newborn screening test will increase from \$14.84 to \$89.25 per baby tested to cover the expanded screening, laboratory and follow-up program costs. Additional laboratory and follow-up staff positions were obtained for the expansion.

The ADH developed a plan for implementation of expanded Newborn Screening to begin July 1, 2008. The plan covered three main areas: medical consultation, including development of Newborn Screening Follow-up protocols; professional development; and public awareness.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Heel stick specimens from newborns are collected by all birthing hospitals in the state, as mandated by law. "Blood spots" are put on absorbent cards.			X	
2. All readings are sent to the Child and Adolescent Health Section where a nurse and a part-time nurse review the results.			X	
3. Abnormal results are reported by mail or fax to the Physician or record on the specimen card and to the family at the address on the card.			X	
4. Telephone contact follow-up is made to determine if the child has had an appointment with the primary care physician.			X	
5. Telephone contact with either the parents or physician obtains information on any confirmatory or follow-up tests, and whether the child is under treatment for a diagnosed disorder.			X	
6. Newborn Screening pamphlet has been revised and will be mailed to birthing hospitals, midwives, local health units and physicians.			X	
7. The Public Health Laboratory Newborn Screening Program and the Newborn Screening Follow-up Program will have a new data base for the expanded screening.				X
8. ADH will expand the Newborn screening program to include the 29 "Core" conditions including cystic fibrosis in July 2008.				X
9.				
10.				

#### **b. Current Activities**

Implementation of the expansion of the Newborn Screening (NBS) Program: July 1, 2008.

ADH has contracted with UAMS, Department of Pediatrics/Arkansas Children's Hospital for sub-specialty technical assistance in developing protocols, collaborating with March of Dimes (MOD) to develop public awareness activities and to develop and stock written patient education materials, and training of Newborn Screening Follow-up Program nursing staff. The newborn screening pamphlet, co-branded with the March of Dimes, is being provided to birthing hospitals, midwives and Arkansas Department of Health Local Health Units. A Newborn Screening web page on the Arkansas Department of Health website is under construction; however the rules and regulations are posted. Public awareness activities included interviews of pediatric and program experts on three statewide TV networks, AM and FM radio, and multiple news outlets. Two new nurses are now hired for the expanded Newborn Screening Program. One has already made site visits to most hospital nurseries. She provides education on expanded newborn screening and collection of specimens. The other newly hired nurse for the Follow-up Program, has completed orientation and attended the Duke training on Tandem Mass Spectrometry Follow-up Program and has provided inservice training for the other follow-up nurses. The expanded NBS Program Follow-up Protocols have been developed. Professional education for doctors has occurred in many venue.

#### **c. Plan for the Coming Year**

Implementation of the expanded newborn screening program July 1, 2008.

Evaluation of implementation in regard to follow-up on abnormal screenings and education of professionals.

Site visits to birthing hospitals across the state by nurse from the Newborn Screening Program to provide technical assistance, in-service education and evaluation of newborn screening policies and practices.

Additional education for Pediatricians, Family Practice physicians, and General Practitioners in the state providing services to children in Arkansas.

Establish contractual relationships with University of Arkansas Medical Sciences/Department of Pediatrics, Arkansas Children's Hospital sub-specialty clinics (Newborn Screening Clinic, Genetics, Endocrine and Comprehensive Sickle Cell) to provide physician consultation and technical assistance, clinic coordination, and monitoring and tracking services for the Newborn Screening Follow-up Program.

Plan to establish MOA with Arkansas Children's Hospital in regard to the 2nd tiered testing and the tracking and monitoring aspects of the NBS Program.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	53	77	55	56	57
Annual Indicator	76.8	53.7	53.7	53.7	61.7
Numerator		12952	12952	12952	468
Denominator		24116	24116	24116	759
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	62	63	64	65	66

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Data from our statewide survey completed in April 2008 was slightly higher at 65%.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

This information was not addressed on the 2006 CSHCN Transition Survey.

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

#### a. Last Year's Accomplishments

NPM 02

Last Years Accomplishments:

Heavy involvement continued with the Part C Early Intervention program last year including development of tools and processes to improve the delivery of services. Late in the SFY, the decision was made to separate the Part C program tasks from the Title V CSHCN and DD program tasks. All except four of the CSHCN caseworkers were relieved of their Part C cases.

***An attachment is included in this section.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN caseworkers make referrals to the Together We Can program in 39 of the states' 75 counties for assistance with funding of less intense services via contract providers. A multi-agency plan of service is developed with the parent/guardian to dete	X	X		
2. CSHCN caseworkers are responsible for working with families of individuals with developmental disabilities & providing referrals to the Special Needs program. This program provides support in funding purchase of items/equipment not covered through an		X		
3. CSHCN caseworkers work with families in intense crisis situations & make referrals to the Integrated Supports program with the permission of the parent/guardian. A multi-agency plan of service is developed with the participation of the parent/guardia		X		
4. Title V Family Support/Respite Program is a program that is available to help meet a child or family's needs. The eligibility requires that the child/youth has been determined disabled by Social Security or the Medical Review Team. The majority of th	X			
5. The CSHCN Parent Advisory Council continues to meet quarterly with members coming from around the State of Arkansas. The members of the council make recommendations for the program & share information with local parent support groups.		X		
6. A small number of CSHCN caseworkers continue to work Part C Early Intervention job tasks. Parental participation in the EI process is required along with satisfaction with the services received.	X			
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **Current Activities:**

Increased activities noted related to utilization of the Title V Family Support/Respite Program being managed between the caseworkers & the Regional Managers. To address the increase, decision making on the requests was pushed down in the chain of command further than has previously been done. CSHCN staff continues to work with families of CSHCN with developmental delays in obtaining services via Integrated Supports (limited contract funding available for expansion) and the Alternative Community Services Home & Community Based Waiver coordinated by the AR DHS Div of Developmental Disabilities. Approximately 400 contacts were made between consumers, their families & CSHCN staff in a period of 4 months.

A random survey was mailed to the parent/guardian of 714 individuals from the CSHCN

database. 202 responses were received.

Questions related to Performance Measure 02 related to satisfaction:

Medical Home: 55% Very Satisfied & 34% Satisfied

Satisfied with Overall Quality of care: Always 70%

Medical Home: Always 68%

Medical Specialists: Always 64%

Communication between Medical Home & Specialist: Always 57%

Questions related to partnering in decision making at all levels: 92%

Understanding proposed medical care: Always 72%

Doctor discusses and addresses CYSHCN needs to help in decisions: Always 68%

Parent/Guardian feels they are a partner in CYSHCN health care: Always 92%

Parent/Guardian ideas/concerns used when decisions were made: Always 77%

### c. Plan for the Coming Year

Plan for the Coming Year:

Continuation of the Title V Family Support/Respite program in its current format is planned. The program will investigate methods utilized by other states to assure parent involvement in a more effective manner.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	53	54	55	56	68
Annual Indicator	52.2	52.2	52.2	65.9	50.2
Numerator				120	379
Denominator				182	755
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	68	68	68	68	68

### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Our statewide survey response to the question "After reading about Medical Home, do you believe your child's primary care doctor meets the qualifications of a Medical Home?" had a "Yes" response of 84%.

### Notes - 2006

Data source: 2006 CSHCN Transition Survey

### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

#### **a. Last Year's Accomplishments**

NPM 03

There were Project DOCC encounters between members of the PAC and resident physicians at UAMS. The Medical Home display unit was set up and manned at statewide and local conferences.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Information on Medical Home was presented in a survey to 714 randomly selected families from the CSHCN database. The families were then asked if they would consider their child's physician a Medical Home.		X		
2. Title V CSHCN Parent Advisory Council is involved Project DOCC (Delivery of Chronic Care) & present information on their life with a child with special needs to resident physicians in a 1:1 meeting in their home.				X
3. Medical Home display & handouts are displayed at meetings statewide to consumers & professionals.				X
4. Assure awareness of the Medical Home concept in all committee/council activities in which Title V professional staff is involved.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Continue Project DOCC activities. The Parent Coordinator for the Title V CSHCN program serves on the Parent as Educators Advisory Committee at AR Children's Hospital. He works with the Project DOCC program to assure the linking of Residents and families of CSHCN.

Display Medical Home display unit at appropriate conferences.

Training scheduled for CSHCN staff in September which will include Medical Home.

Provided a description of a Medical Home to and surveyed 714 families on how their primary care provider measured up as a Medical Home. The results were as follows:

After reading about Medical Home, do you believe your child's primary care doctor meets the qualifications of a Medical Home: Yes 84%; No 10%; No answer 6%.

Does your child have a regular doctor or clinic for health care? Yes 98%

93% of respondents stated that they go to a doctor's office for health care; but only 65% are able to reach the doctor after hours.

#### **c. Plan for the Coming Year**

Continue training of CSHCN staff who can then train families during one on one contact.

Distribute Medical Home materials to staff.  
 Display Medical Home information at appropriate conferences.  
 Continue to provide Medical Home information to peers when participating in committees or other outreach activities.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	56	67	56	57	62
Annual Indicator	66.3	54.5	54.5	61.5	66.5
Numerator		103	103	112	493
Denominator		189	189	182	741
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	66	67	68	69	70

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Our statewide survey completed in April 2008 indicates that 65% of respondents state that insurance (public or private) covers the cost of their child's care. Yet on a question about out of pocket medical costs with 92 affirmative respondents, 47% paid from \$1 to \$1000 per year and 28% paid over \$1000 per year out of pocket.

**Notes - 2006**

Data source: 2006 CSHCN Transition Survey

**Notes - 2005**

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

**a. Last Year's Accomplishments**

NPM 04

The program worked with families with private insurance and/or Medicaid to obtain care and services required by the CSHCN. Shared information on the various categories of Medicaid coverage available in Arkansas and made appropriate referrals to those programs. Continued to work with the state's only Pediatric tertiary care center, Arkansas Children's Hospital, to provide coverage for eligible children/youth; provide payment for diagnostic evaluations; offered Title V Family Support/Respite program to all CYSHCN on the list of SSI enrollees on a first come, first served basis for a limited number of grants (300); provided coverage as funding allowed for services not covered by Medicaid.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided payment for care for 253 CSHCN in combination with private health insurance at AR Children's Hospital & other local hospitals & medical providers around the state.	X			
2. Provided payment for diagnostic workups on approximately 262 children who were suspected of having an eligible condition in combination with private insurance providers.	X			
3. Evaluated all applicants for possibility of eligibility for other financial & disability categories of Medicaid.		X		
4. Provided payment for services for 146 Medicaid recipients that were not covered under the Medicaid state plan (purchase of medical equipment, van lifts, ramps, compound drugs, medical food for PKU, etc).	X			
5. Provided payment for Family Support/Respite/Medical Camp for approximately 175 CSHCN with Medicaid coverage.	X			
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

NPM 04

A revision of the Title V Family Support/Respite Program involved movement of the approval of applications to the regional level. The program funding is available to the caseworkers as they work with their cases or become aware of families who have the immediate need. The program process is much more manageable this year after movement of the payment processing directly into our work unit.

**c. Plan for the Coming Year**

NPM 04

The program will begin discussions within the agency about moving back to a contract with Arkansas Children's Hospital to improve this labor intensive process. Over 90% of the applications for financial assistance in paying for medical care for CSHCN originate at this facility. Three of the program's RN caseworkers spend 95% of their time in this process. It is anticipated that making such a change would increase the time these RN caseworkers have to provide care coordination.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective	71	72	50	51	52
Annual Indicator	71.6	48.9	48.9	48.9	89.1
Numerator		64	64	64	688
Denominator		131	131	131	772
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	90	90	90	90	90

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

This information was not addressed on the 2006 CSHCN Transition Survey

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

#### a. Last Year's Accomplishments

Title V CSHCN staff in 21 community based offices serve as primary contacts for Title V and several other programs for individuals with special needs. Contact with other Divisions within the Arkansas Department of Human Services routinely takes place for individual consumers in need of services. Presentations have been done for Foster Care workers in several counties to assist them in the referral process for Title V, Part C and DDS programs. Presentations have been done for parent support groups and parent training sessions coordinated by the Arkansas Disability Coalition. The Parent Coordinator attends Parent Support Group meetings that are sponsored by PAC representatives. He provides information and resource material to those in attendance. He initiates contact between families and Title V CSHCN staff when needed.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN staff serves as care coordinator for children/youth & their families who have requested such assistance. Care coordination activities include completion of an individualized Needs Assessment & development of a Plan of Care; other activities inc	X			
2. CSHCN staff serves as primary contacts for several programs within the Division of Developmental Disabilities Services & assist in completion of & gathering of necessary paperwork to access those programs & enable the family & CSHCN to receive	X			

servic				
3. CSHCN staff serves on local Interagency Coordination Councils to assist in development of the local infrastructure for serving children with special needs.				X
4. CSHCN staff participates in public awareness activities by making visits to local medical offices, DHS offices & local providers within the community to provide information on the various programs available.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

Title V staff now are more fully able to work in community coalitions and work groups. Some of the activities include: attendance at local Interagency Coordinating Councils, Hometown Health Coalitions, Together We Can and CASSP councils (both local and state) and local DHS Management Teams. Title V staff participated in focus groups for the Natural Wonders project funded by a coalition including AR Advocates for Children and Families, AR Blue Cross Blue Shield, AR Center for Health Information, AR American Academy of Pediatrics, AR Children's Hospital, AR DHS, UAMS College of Public Health, UAMS College of Medicine, AR Kids Count Coalition and the University of AR Clinton School of Public Services. Attendees at each locale were encouraged to discuss issues in their area of interest. Some issues discussed by attendees included access to health care, health care discrepancies and quality of care. Title V staff participate in the Assuring Better Child Health and Development (ABCD) Stakeholders Group along with partners from MCH. This group has worked with AR Medicaid and their contractor AR Foundation for Medical Care to improve the EPSDT screening rates in AR. A joint recommendation for selection of Developmental and Autism screening tools for use at prescribed times has been made. Incentives will be effective in September 2008 and Medicaid payment for the administration of the Developmental and Autism screening tools will become effective in the upcoming state fiscal year.

#### c. Plan for the Coming Year

The CSHCN program staff will increase the amount of time involved in public awareness of the programs that are available for CSHCN & their families.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6	7	11	11	15
Annual Indicator	5.3	10.5	10.5	10.5	33.1
Numerator		4	4	4	114
Denominator		38	38	38	344
Check this box if you cannot report the numerator because					
1. There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	34	35	36	37	38

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Our statewide survey mirrors the National Survey of CSHCN with a 33% response to question asking if there is a Transition Plan in place.

#### Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

This information was not address on the 2006 CSHCN Transition Survey

#### Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

#### a. Last Year's Accomplishments

NPM 06

Mail-out of a transition-focused survey to youth on the CSHCN database in the month of their 14th birthday. A program display was set-up at Transition Fairs hosted by the Local Education Cooperatives around the state. The Title V Parent Coordinator completed the development of Transition Tip Sheets. These are used by staff when working with YSHCN & provided in the aforementioned display. CSHCN caseworkers assist families & YSHCN apply for the DDS Alternative Community Services Home & Community Based Waiver.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition surveys were received from 125 young people with responses that assist our program in planning services for the individual.		X		
2. Participate in Arkansas Interagency Transition Partnership with members from Dept of Education, Higher Education, Disability Rights, Rehabilitation Services & DHS agencies serving adolescents & young adults (DDS, Children & Family Services, Behaviora				X
3. Work with individual YSHCN & local transition representatives to develop transition plans.		X		
4. CSHCN staff work with local councils to staff Transition Fairs in the Dept of Education's regional Local Education Cooperatives. The fairs are attended by youth throughout several school districts who are served by Special Education &				X

504.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The program continues to send the Transition Survey to YSHCN in the month of their 14th birthday. Survey responses indicating a problem or a need for assistance are forwarded to the CSHCN caseworker. CSHCN caseworkers make individual contact with individuals on their case management caseload re: transition needs. Newsletter articles provide information on transition issues to a larger forum. CSHCN caseworkers assist individuals with developmental disabilities in application for the DDS Alternative Community Services Home and Community Based waiver. Parent Coordinator, Rodney Farley, has attended 5 Transition Fairs held at Educational Cooperatives around Arkansas this past school year. He and other staff attended a Transition Summit in February 2008 where they displayed Title V CSHCN materials, Transition Tip Sheets and other resource materials. He also represented the Title V CSHCN program at a Youth Committee mentoring meeting.

#### **c. Plan for the Coming Year**

In addition to ongoing efforts in transition, training targeted toward transition objectives, resources and issues is planned for the CSHCN staff in September 2008.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	91	77.2	80	85	87
Annual Indicator	68.5	78.9	83.4	86.8	84.0
Numerator	2932	3266	3269	3375	4176
Denominator	4283	4139	3921	3887	4969
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	88	89	90	91	95

#### **Notes - 2007**

2007 data are from the Comprehensive Clinic Assessment Software Application (Co-CASA) program from the Vaccines for Children (VFC) Program.

The denominator is the number of children sampled at the local health units. The numerator is the number of children with complete vaccine records from those sampled.

The data are from ADH local health units and do not include private providers.

#### **a. Last Year's Accomplishments**

NPM 07

For children 24 through 35 months of age seen in local health unit clinics and some private providers' offices, the 2007 age-appropriate immunization rate was 84%. The National immunization Survey conducted by the National Immunization Program had Arkansas's immunization rates at 75.0 (CI plus/minus 8.8) for children seen in both public and private clinics. This ranking is below the national average of 80.6% and does not meet the 2010 Goal or 80% age-appropriate immunization rates for Arkansas's two year old children. While this survey is the basis for reporting two year old immunization rates, it is based on evaluating the immunization records of less than 200 children. The internal evaluation of the state's immunization rates is based on analysis of many more immunization records and is believed to better represent the actual rates.

The Immunization Section continually works to attract more providers utilizing the immunization registry to make a more comprehensive immunization data base with immunization records readily available to both providers and parents. The immunization registry is web-based and currently 98% of the 540 providers report immunization information on a real-time basis or via batch downloads using HL7 to the registry via computers in their offices.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Birth certificates for all babies are registered in the statewide Immunization Registry (IR).			X	
2. Immunizations provided to the child, if any, during the newborn hospitalization are entered in the IR.			X	
3. Through a collaborative program called "Vaccines for Children" the health department immunization clinics and primary care physicians' offices provide immunizations according to the national ACIP recommendations			X	
4. Immunizations given in local health units and in primary care physicians' offices are entered into the IR. Offices have direct on-line entry access or electronic upload capabilities.			X	
5. In recent years the Health Department IR staff and leaders have made great strides in training both public and private clinic staff and school nurses in data entry. They are beginning this training for licensed childcare facilities.			X	
6. By comparison to birth records, the IR is tracking the vast majority of children.			X	
7. Recently implemented vaccines include human papillomavirus, rotavirus, meningococcal, and adult pertussis, and will have a high priority in local health units.			X	
8. Public health offices use reminders and call-backs of local health unit clients (e.g., WIC infants) to assure completeness of immunizations received.			X	
9. The IR has reminder and recall capabilities.				X
10. There is a legislative mandate that requires reporting of all				X

immunizations given to individuals less than 22 years of age to the IR by health care providers.				
--	--	--	--	--

#### **b. Current Activities**

The immunization Section, through ADH's 94 local health units, routinely offers all vaccines necessary to age-appropriately immunize children. Each local health unit provides all immunization services, and is able to identify children who are delinquent on needed doses of vaccine. Follow-up activities are initiated and designed to prompt parents/guardians to bring children into clinics to receive needed doses of vaccine. Additionally, the Immunization Section has Vaccines For Children (VFC) regional colleagues who promote immunization activities in private physician's offices throughout the state. These activities include conducting an assessment of the patient's immunization status and providing technical assistance on conducting follow-up activities with children to increase immunization rates. The immunization Section, through the regional colleagues, continually solicits participation of all clinics, both public and private, to participate in the VFC Program therefore enabling the Department of Health to expand availability of services across Arkansas. The web-based immunization registry is a considerable upgrade from the old system and greatly enhances the overall service delivery activities. It allows public and private providers quick access to their patient's immunization records and real-time updating of individual immunization records. The Immunization Registry Team places priority on training and recruitment of additional providers utilizing the registry.

#### **c. Plan for the Coming Year**

The immunization Section has recently implemented the use of newly licensed vaccines for use in ADH's immunization clinics such as the human papillomavirus (Gardasil), rotavirus, meningococcal (Menactra) and adult pertussis (Tdap). The use of these new vaccines will be a high priority in ADH's local health units in an effort to reduce the morbidity and mortality associated with these diseases.

The Immunization Section will continue to promote the immunization of Arkansas's children through the Vaccines For Children (VCF) Program. The Section will identify areas in the state that have low immunization rates and intensify efforts to immunize individuals delinquent on receiving needed vaccines. The Immunization Registry Team will continue to promote utilization of the web-based registry. The regional colleagues will continue to promote participation of all immunization providers in the VCF Program. Clinics will be assessed routinely to determine the age-appropriate immunization status of the children they serve so that steps can be taken to increase immunization rates. The Section will also stay abreast of activities in other states and will implement those activities that have been proven to increase immunization rates.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	37	36	28	28	31
Annual Indicator	30.5	30.4	29.0	30.5	30.3
Numerator	1725	1715	1661	1796	1784
Denominator	56578	56502	57234	58842	58842
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	32	33	33	34	34

#### Notes - 2007

2006 female population 15-17 years was used to compute 2007 rate.

The Abstinence Education and Unwed Birth Prevention activities, which are aimed at teen pregnancy prevention, have been significantly cutback due to reductions in state and other funding. In addition, the Federal funds for abstinence education have been harder to utilize due to the uncertainty and delayed disbursement of the funds from the federal government.

#### Notes - 2006

Used 2005 population estimate 15-17 years for 2006 indicator.

#### Notes - 2005

2005 data are provisional.

#### a. Last Year's Accomplishments

##### NPM 08

Teen pregnancy reduction continued to be a high priority within the Department of Health. Family Planning Title X provided funds for family planning efforts in 85 local health units and one contracted agency. Reduction of unplanned pregnancies for all women continues as a high priority. Efforts by each county's local health units included a standard of operation of a minimum of two outreach efforts each year that focused on hard to reach populations. Sub-grants for Unwed Birth Prevention provided funds for nine county coalitions to develop pregnancy prevention and education activities. The coalitions' activities reached teens in schools, after school activities/clubs and faith-based organizations. Technical assistance is provided.

The Abstinence Education Program (AEP) funded 10 community projects during the past federal fiscal year. These grants, and many that have preceded, participated in a health-behavioral research which used evaluations. The evaluator, Institute for Research and Evaluation, for the last 5 years, has provided regular reports on the overall evaluation and by project. Technical assistance was provided to all active sub-grantees. The Phase V Interim Report was received May 2007. Positive improvements among students receiving abstinence education were noted during the time the abstinence education activities were received. However, twelve months after the close of the intervention, the students' reported knowledge, attitudes, and behavioral intentions were not measurably different from comparison peers. Improvement in students' attitudes and intentions toward sexual activity reverted back to where they were before they started the program. A Final Title V Report, which will include the data through the end of June 2007, is anticipated by July 14, 2008. The ADH Grant Program Managers will utilize this information to improve the effectiveness of the overall program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide public awareness campaigns are being conducted to maintain public vigilance for adolescent pregnancy (Healthier Babies Campaign)			X	X
2. Teen births rates are published to all counties on the ADH web page.			X	X
3. Teen pregnancy rates by county are being tracked especially			X	X

in those counties that have Abstinence Education and Unwed Birth special projects.				
4. Abstinence Education Programs are being conducted in 10 sites, funded by a combination of HRSA grants and State funds by ADH.		X		
5. The Abstinence Education Projects have been scientifically evaluated by the Institute for Research and Evaluation by surveys of teens that are 1) highly involved in, 2) somewhat involved in, and 3) not involved in educational interventions.				X
6. Family Planning clinics in 92 Health Unit locations provide free or reduced cost contraceptive services in all counties for adolescents.	X	X		
7. Unwed Teenage Pregnancy Prevention Projects were conducted in 8 counties, funded by Family Planning Medicaid Waiver Income.		X		
8.				
9.				
10.				

#### **b. Current Activities**

The Agency is requesting state funding to provide for the continuation of the Unwed Birth Prevention and Prevention of Second Order Birth sub-grants. ADH Women's Health provides funds to support the local health unit's Hometown Health Initiatives (HHI). The HHI's activities include outreach to teens and hard to reach populations. Women's Health provides technical assistance for the HHI's.

During State Fiscal Year 2007, the State General Assembly appropriated \$350,000 for the AEP for SFY 08 and additionally for SFY 09. In May 2007, the State was notified by the Administration for Children and Families that funding was ending June 30, 2007. In July 2007, the State was notified that the program was authorized through September 30, 2007. In October 2007, the State was notified that federal funding was being extended until December 30, 2007, leaving a short time period to award funds to the 10 FY07 sub-grantees. Similarly in February 2008, the state received a grant award for the second quarter of 2008, in March 2008 a grant award for 3rd quarter, then notification that the federal program was extended until June 30, 2008. There are currently 8 FY08 sub-grants awarded to schools, faith, and community-based organizations throughout the state, targeting youth ages 12 to 29 years. The State amended the 8 sub-grants to award the remaining federal funds. Monitoring and tracking along with process evaluation and data collection are continuing for current projects.

#### **c. Plan for the Coming Year**

Plans are for the Family Planning Program to continue its outreach efforts to teenagers through the local health units in each county. ADH Regional Directors are considering the addition of family planning clinic sites. ADH will work with the Unwed Birth Prevention and Second Order Birth Prevention sub-grantees, as well as the Family Planning Title X sub-grantees at Ouachita Children's Center and Wilbur Mills Substance Abuse Program in these efforts to reach teens and other high risk populations. ADH continues to monitor and evaluate the Family Planning Program per Title X requirements.

The Abstinence Education Request for Application to award sub-grants to schools, faith, and community-based organizations, using the state appropriated funds, was released in April 2008, and 7 sub-grants were selected by the Grant Review Committee. The State is in the process of putting in place the 7 sub-grants. ADH awaits further notice on availability of Federal funding after June 30, 2008. The program is expecting communication from the Governor's office regarding appointees to the Steering Committee on Abstinence Education.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	28	29	30	16	18
Annual Indicator	14.9	15.0	15.0	15.0	15.0
Numerator	5012	1071	1071	656	197
Denominator	33642	7138	7138	4376	1312
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	19	20	20	20	20

**Notes - 2007**

A statewide dental screening survey was not conducted in 2007. Results are limited to dental screenings done by request of a local agency or organization.

**Notes - 2006**

A statewide dental screening survey was not conducted in 2006. Results are limited to "convenience samples" which are dental screenings done by request of a local agency or organization. Hence, the smaller numbers in the denominator and numerator cells.

**Notes - 2005**

Prepopulated with 2004 as survey is not done every year

**a. Last Year's Accomplishments**

**NPM 09**

Many programs of the Office of Oral Health (OOH) are funded by the Centers for Disease Control and Prevention to augment the state oral health program. Under the Chronic Disease Prevention grant of \$344,964, the OOH is building infrastructure and capacity within the State oral health program, supporting the Arkansas Oral Health Coalition, Inc. and expanding or creating effective programs to improve oral health outcomes and reduce disparities.

CDC grant funding has provided for additional staff, including the recent addition of a state sealant coordinator. The grant also provided funds to better assess oral health in Arkansas, to design new programs on dental sealants, tobacco cessation and prevention, and family violence prevention. The Office of Oral Health, working with various community leaders, has increased community water fluoridation in Arkansas to 64% of those people on water systems.

Working alongside the Arkansas Oral Health Coalition, OOH continued to support dental sealant programs in the state. With funding from the Daughters of Charity Foundation, OOH embarked on a three-year program leading to the "Seal the State in 2008" project. Through this project, dental sealant awareness programs have occurred in all 75 counties along with direct services for 2,500 at-risk children. Together with comprehensive dental care provided by contract dentists, dental hygiene students from UAMS rotated through a school-based weekly clinic in Little Rock that ADH and partners formed, providing dental sealants to more than 400 children. In western

Arkansas, a project in collaboration with Health Connections and UAMS Dental Hygiene Program provided dental sealants to almost 200 students.

Other initiatives include numerous presentations on family violence prevention presented to various health care professionals, Head Start agencies and lay audiences. Also, the successful Spit Tobacco Prevention Night with the Arkansas Travelers' minor league professional baseball team -- based on the slogan, "Spit Tobacco: Chew, Dip and Die," is now in its seventh year. Head Start dental exams are performed when requested by Head Start staff.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In recent years the Oral Health Program has conducted oral examinations of children in third grade in a randomly selected group of schools in the state. This survey is expensive and is not done every year.			X	
2. Through the Seal the State project, several initiatives to provide sealants to children around the state have taken place and will continue to partner with other programs and agencies.				X
3. The importance of oral health care has been repeatedly emphasized in community based projects. Tee shirts, tooth brushes, and other premiums have been distributed in many communities throughout the state.			X	
4. The Governor's Summit on Oral health is held every year with an attendance rate of about 100 dentists, dental hygienists, dental assistants, and other interested parties.			X	
5. A statewide Oral Health Advisory Council is active every year.			X	
6. In addition to the issue of protective sealants, the Office of Oral Health continues to advocate for and assist communities to fluoridate their water supplies.				X
7. Dr. Mouden is very active in attending municipal and county meetings regarding decision to fluoridate water supplies.				X
8. The Health Connections Section of ADH has developed a contract with Medicaid to establish more positions for the ConnectCare telephone helpline to link Medicaid recipients to dentists throughout the state.			X	
9.				
10.				

#### **b. Current Activities**

The OOH continues to assess oral health across Arkansas, including open mouth surveys for children, adults and the elderly.

Year two of Seal the State will be held in 21 Arkansas schools, with plans to deliver dental sealants to approximately 2,000 children. In addition, the awareness media campaign is designed to reach all 75 Arkansas counties with information about the importance of dental sealants.

Oral health workforce initiatives include funding dental recruitments efforts by the Primary Care Association, providing Grants-in-Aid to new dentists practicing in underserved areas, promoting dental careers in minority and rural populations, promoting language translation services in dental offices, and increasing awareness on family violence prevention.

The CDC grant supports the "Governor's Oral Health Summit," now in its seventh year. The grant also provided additional support for improving the community water fluoridation program in Arkansas. The grant funds educational opportunities to further acceptance of fluoridation among policy makers, health care professionals, civic leaders, water plant personnel, and citizens, all based on the slogan, "Got Teeth? Get Fluoride!"

The Health Connections Section of the Arkansas Department of Health has developed its ConnectCare contract with Medicaid to establish more positions for the ConnectCare telephone helpline to link Medicaid recipients to dentists throughout the state.

### c. Plan for the Coming Year

The OOH is in its second year for the Seal the State project. The grant will help increase awareness about the importance of dental sealants and encourage more dentists and dental hygienists to provide this important service.

Expansion of community water fluoridation continues to be a major focus for the OOH.

Tobacco prevention, injury prevention and family violence prevention are all focus areas for educating healthcare professionals and lay audiences.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	10.4	10.3	7	4.2	6
Annual Indicator	6.7	7.3	5.7	7.5	4.9
Numerator	38	41	32	43	28
Denominator	565382	565382	557472	569943	569943
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	6	6	6	5.8	5.8

#### Notes - 2007

2006 population estimate 0-14 years was used to calculate 2007 rate.

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

#### Notes - 2006

Used 2005 population estimate 0 - 14 years for 2006 indicator.

#### Notes - 2005

The 2004 population estimate was used as a denominator for the 2005 rate indicator.

#### a. Last Year's Accomplishments

##### NPM 10

The Arkansas State Police managed the "Click-It or Ticket" campaign to implement the state's seat belt law. This law does not recognize non-use of seat belts as a "primary offense." Attempts have been made in legislative sessions to make it a "primary" infraction.

The ADH Injury Prevention Program staff has collaborated closely with the Safe Kids Coalition that is managed by UAMS and Arkansas Children's Hospital. The Injury Prevention Program made posters available to all Local Health Units with revised Child Passenger Safety Seat legislation high-points.

The ADH Injury Prevention program also distributed literature through school health fairs, faith-based organizations, and Hometown Health Coalitions.

Working with Mary Aitken MD, MPH at Arkansas Children's Hospital, a student from the College of Public Health has analyzed and published data from a county in north-central Arkansas that experienced a very high rate of injuries due to all-terrain vehicles. That research effort has turned into a public awareness campaign in that county and elsewhere.

The Injury Prevention Branch furnished various unintentional injury brochures/educational materials to local communities for distribution through health fairs, in-service training opportunities, and community events. Topics have included safety information on all terrain vehicles, poisoning prevention, burn prevention, playground safety, falls, window cord and motor vehicle safety for teens pursuing drivers permits.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division of Health is working closely with UAMS on child safety seats campaigns.			X	X
2. The College of Public Health and Children's Hospital are working on an injury prevention campaign relative to all terrain vehicles. Arkansas has a very high rate for these casualties nationwide. Rural Newton County has the highest rate in Arkansas.			X	
3. Impact of community-based ATV injury prevention efforts is under way using community observers.			X	
4. The Division of Health works with the Arkansas State Police and the National Highway Transportation Safety Agency on new legislation to tighten seat belt laws.				X
5. ADH collaborates with the Safe Kids Coalition to continue public awareness and preventive activities in the state			X	X
6.				
7.				
8.				

9.				
10.				

#### **b. Current Activities**

Activities listed above continue in this year.

The Injury Prevention Program is focusing its efforts primarily in the area of prevention of unintentional injury.

The Arkansas Department of Health is now preparing to approach the Arkansas General Assembly to fund a Trauma System proposal, which would create a Level I Center in the state, and provide for upgrading the whole system to protect as much as possible, all citizens who are injured. As part of that Center, it is likely that the Arkansas Children's Hospital would serve as the Level I facility for children.

The issue for getting this accomplished has been finding the appropriation. In mid-July 2008 Governor Beebe announced his intention to provide \$200,000 from the Governor's Emergency Fund towards collection of data to be provided to the legislature.

#### **c. Plan for the Coming Year**

The Program will continue to support schools and churches that are part of the Injury Prevention public awareness efforts, as well as support for Hometown Health Coalitions.

The Program will continue its collaboration with the Safe Kids Coalition and with the Arkansas State Police.

The Program continues to support the community based program to prevent injury due to fires and falls. This effort is carried out in communities by active volunteers from fire departments throughout the state.

ADH will be one of the lead agencies in support of the creation of the Trauma System proposed for the Arkansas General Assembly.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				14	25
Annual Indicator			13.6	24.6	23.4
Numerator			3425	8960	8913
Denominator			25095	36481	38017
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	26	27	28	28	29

#### **Notes - 2007**

2007 source is 2006 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2006.

Numerator is total (weighted) number of women who responded "Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2006 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

#### **Notes - 2006**

2005 data was percent of WIC mothers that breastfed their infants at 6 months of age.

2006 source is 2005 PRAMS survey.

Denominator is total (weighted) number of women surveyed.

Numerator is total (weighted) number of women who responded "Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2005 PRAMS survey.

The age of infants ranges from 2 months to 9 months.

#### **a. Last Year's Accomplishments**

During the year, the Third Annual Breastfeeding: A Course for Health Professionals was offered for continuing education hours for nurses, dietitians, home economists and breastfeeding counselors. Competency-based breastfeeding self-study training modules for WIC professionals and support staff was also offered through A-Train (CEU hours were approved for professional staff).

A Mother's Day Project to honor local breastfeeding mothers statewide was implemented during the month of May. Photographs of breastfeeding mothers and their breastfed children were used to design a poster with diverse audience appeal that was displayed at every local health unit. Local and state level media activities were planned to celebrate the breastfeeding mothers during the month of May.

A breastfeeding collaborative project piloted with other states in the USDA Southwest Region to increase initiation of breastfeeding during the 2006 to 2007 year was expanded. The evaluation results were positive and showed that distributing the education bag and materials to a larger audience could significantly increase the number of WIC moms who breastfeed.

The 3rd quarter nutrition education plan for pregnant will focus on breastfeeding and incorporate the World Breastfeeding Week theme of Mother Support. A toll-free Breastfeeding Helpline was operational. Each Health Unit has an onsite breastfeeding contact person to coordinate the local breastfeeding support and promotion plan. Local Health Unit staff maintained a clinic environment that endorsed breastfeeding. For example, there is a requirement that no formula displays or items displaying formulas or company names can be displayed. Areas are designated for moms who want or need to breastfeed. Each Local Health Unit provided at least one breastfeeding promotion project for the year, this included health fairs, lobby or clinic displays, and participation in World Breastfeeding Week displays.

Breastfeeding peer counselors as a resource to mothers has been shown in national data as making significant contributions to breastfeeding rates. The ADH WIC program continues working to find funds to expand the peer counselors' efforts. An additional three peer counselors positions were approved, filled and are being trained this year.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC, during Certification of pregnant women, provides breast feeding education for all participants.	X			
2. Through out the pregnancy, WIC counselors revisit this issue with pregnant women to reinforce their knowledge of the specifics of breastfeeding.	X			
3. WIC policy in Local Health Units requires that the unit environment be breastfeeding "friendly" including posters and brochures readily available to clients. In addition commercial advertising for formula products is minimized in the health unit.		X		
4. Breast feeding peer counselors are known to be effective in helping mothers start to breastfeed, and WIC is looking for resources to fund more of them.			X	
5. In the USDA Southwest Region of the US, a new pilot project will be expanded with participation by each state. The target group for this pilot is pregnant women on WIC, among whom breastfeeding rates both in the hospital and at 6 months are very low.			X	
6. WIC breastfeeding experts conduct annual trainings not only for Health Division staff, but for health professionals throughout the state. The trainings are attended by hospital personnel, especially nurses, nutritionists, lactation specialists, and b				X
7. The value to the child's health of breastfeeding is underscored with many public awareness efforts such as the Healthier Baby Campaign.				X
8. A monthly breastfeeding "Quick Notes" electronic newsletter is sent to all WIC staff through the local health units.				X
9.				
10.				

**b. Current Activities**

Currently, the monthly breastfeeding "Quick Notes" newsletter is sent out to all WIC staff through each Local Health Unit breastfeeding contact.

Breastfeeding rates are provided to Local Health Units on a monthly basis.

Participation in the activities described above is ongoing.

**c. Plan for the Coming Year**

The Fourth Annual Breastfeeding: A Course for Health Professionals will be made available to 75 health professionals statewide. The course is co-sponsored by the Arkansas Department of Health-WIC, Arkansas Children's Hospital and the University of Arkansas for the Medical Sciences, College of Medicine.

Approximately 17,000 WIC breastfeeding education bags will be distributed in 50 counties of the state targeting pregnant women at the initial WIC certification visit beginning this fall 2008.

To capture data on the activity of breast feeding at 6 months of the baby's age can be done only for WIC patients. However, PRAMS data surveys women in the 2nd to 4th month after a delivery. That data has provided a more population-wide view of breastfeeding practices, a picture that is quite different from the behavioral choices of women on WIC. ADH and the Arkansas WIC program prefers to present data on breastfeeding progress taken from PRAMS data, which

means the definition of the measure would have to change from 6 months to "at the time of the PRAMS survey."

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	70	75	97	97.9	98.3
Annual Indicator	97.5	96.5	97.8	98.2	98.2
Numerator	34174	35059	36789	37866	38978
Denominator	35049	36348	37610	38573	39682
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	98.4	98.5	98.6	98.6	98.6

**Notes - 2007**

Denominator is number of forms received from hospitals (39,682). Numerator is number of infants (reported on forms) that received hearing screens (38,978).

**Notes - 2006**

Denominator is number of forms received from hospitals (38,573). Numerator is number of infants (reported on forms) that received hearing screens (37,866).

**Notes - 2005**

Denominator is number of forms received from hospitals (37,610). Numerator is number of infants (reported on forms) that received hearing screens (36,789).

**a. Last Year's Accomplishments**

The Infant Hearing Program (IHP) sought collaborative relationships with intra-agency programs and with public and private agencies for the provision of services toward identification of infants/children with hearing loss and necessary follow-up intervention. The IHP was instrumental in establishing limited data sharing from Part C Early Intervention Services, co-sponsorship of workshops for Part B and Part C service providers, and as a partner in expanded hearing screenings to Early Headstart Programs. In addition, user friendly modifications for the IHP database and client server were implemented.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Universal hearing screening in the hospitalization of birth is mandated by state law. Only hospitals delivering < 50 babies per year are exempted. This is a very small number of births. Lay midwives are also required to arrange for hearing screens				X
2. The program provides hospitals with technical assistance in				X

physiologic testing and equipment purchase, and a four-part form for documenting the hearing screen results				
3. A database is kept in the Division of Health, populated with birth certificates to which all hearing screening information is matched for each baby. Monthly reports of this data are sent to reporting hospitals.				X
4. The program identifies all abnormal reports and notifies both physicians and parents of the need for followup testing. Telephone calls with both physicians and parents are made when necessary to assure this follow-up.				X
5. Confirmatory audiologists' testing results are reported to the database.				X
6. The program is guided by an advisory council of experts, and supported by CDC to conduct a research survey of parents.				X
7. Public awareness campaigns using mass media are conducted, but not every year.				X
8. The program works with Early Intervention Part C to assure audiologic followup for children with special health care needs.				X
9. Investigation is now taking place regarding linking of the hearing registry to other registries to begin a more universal child health data base.				X
10. The program will institute a "customer survey" designed to provide feedback from parents' regarding information they received related to the newborn hearing screen experience at the birthing hospital, to identify hospitals that need additional techni				X

#### **b. Current Activities**

The IHP and the Arkansas Department of Health's Information Technology Services (ITS) are developing an ad hoc reporting system in Business Objects software with report capability for individualized information for infants/children through the entire process of newborn hearing screening, follow-up testing, and diagnostic evaluation results. The IHP has also provided cultural competency training for Part C service providers and public school personnel working with the Latino population. The IHP has disseminated educational materials to babies' Primary Care Physicians and is currently revising the program's direct website with new physician and parent information.

#### **c. Plan for the Coming Year**

A major focus for the coming year will be enhancement of the IHP data system through a link to the Electronic Birth Certificate (EBC). The program will collaborate with the state Health Statistics/Vital Records Department for an electronic link through the EBC to collect demographic data, hearing screen results and other vital data information for data capture, tracking, and state/federal reporting criteria. The revision to an electronic format will allow data from hospitals to be received more quickly than with the program's paper based system; thereby, resulting in more timely follow-up of infants needing additional testing.

The IHP also plans to work with the Universal Newborn Hearing Screening, Tracking, and Intervention Advisory Board (UNHS) for revision of existing hospital screening guidelines. The Joint Committee on Infant Hearing, 2007 Statement, will be incorporated into the state guidelines, as appropriate. The IHP program plans include improvement activities directed at the initial hearing screening level with changes in quality assurances measures. The IHP staff will solicit input from stakeholders within the ADH five regional areas to identify barriers and solutions toward reducing the number of infants/children that do not return for follow-up hearing screening.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	12	10	7	7	10.8
Annual Indicator	13.0	6.8	10.7	9.3	9.3
Numerator	93990	47000	72000	65000	65000
Denominator	723000	692000	673000	699000	699000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	10.8	10.7	10.7	10.7	10.6

**Notes - 2007**

2007 prepopulated with 2006 data. Source: U.S. Census Bureau, Current Population Survey, 2000 to 2007 Annual Social and Economic Supplements.

**Notes - 2006**

2004 - 2006 data are estimates. Source: U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements.

**Notes - 2005**

2004 - 2005 data are estimates. Source: U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements.

**a. Last Year's Accomplishments**

1. The Health Connections Section (HCS) now covers health information services not necessarily funded by the Medicaid ConnectCare contract. The Medicaid ConnectCare contract includes PCP assignment and dental managed care. Additional programs in HCS include health information support for prenatal care (Campaign for Healthy Babies), smoking cessation (Clean Indoor Air), and information related to WIC, Immunizations and many other services.

2. HCS health education staff visited communities, Head Start services, schools and day care centers to find potentially eligible children and get them enrolled as well as assist in health information needs and resource development.

3. HCS staff operated the Arkansas Health Information helpline on an 8:00 am to 4:30 pm basis five days a week, providing information on accessing services in general. Information on a wide variety of community sources of care is shared with callers, to connect callers to all health resources, including Medicaid.

4. HCS staff, funded through the Medicaid ConnectCare contract, operated the ConnectCare helpline from midnight on Sunday through midnight on Friday to help callers apply for Medicaid benefits, and to help enrolled recipients to obtain a primary care physician.

5. HCS staff produce a variety of newsletters, brochures and other written materials to send to callers as needed on a variety of health issues, especially for concerns regarding prenatal care,

smoking and obesity.

6. Over the past several years, Medicaid has streamlined the application processes for families to get their children on AR Kids A & B programs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach through presentations to Headstart and other early childhood care providers.		X		X
2. Connect Care outreach education coordinator supplied by program to participate in Coordinated School Health to connect kids to health services.		X	X	X
3. AR Kids Health Days will be held to promote well child checks, EPSDT screens, general health services, and other preventive care available through their assigned primary care physician.		X		X
4. 1-800 telephone line and a website for access to information to all callers in cluding health and dental service providers.		X		X
5. Media such as educational brochures, quarterly newsletters, county and statewide primary care and dentist provider lists.		X		X
6. The Connect Care activities will increasingly be targeted to potential and actual Medicaid recipients for all life stages for women, as well as to all children.		X		X
7. The Connect Care database will be updated each month to assure accurate information is available to recipients to choose their PCP and dentist assignments.		X	X	X
8. The Health Connections Health Promotion staff will assist Human Service Workers in schools in health information needs and resource development.		X	X	X
9.				
10.				

**b. Current Activities**

1. Activities listed in items 1-5 continue this year.

2. HCS has been developing its ConnectCare contract with Medicaid to establish more positions for the ConnectCare helpline to link Medicaid recipients to primary care physicians and dentists throughout the state.

3. HCS is developing its role as a resource to support Human Service Workers in schools to assure that students are healthy and ready to learn. Access to a wide variety of services for students will be enhanced including Medicaid, mental and dental health, and other social and health services.

**c. Plan for the Coming Year**

1. Health Connections Section will continue those activities listed under "current year" above.

2. HCS will implement the dental provider referrals and call backs. HCS will look for other ways in which to improve recipient and potential recipient knowledge and skills in using the health care system.

3. HCS will be building relationships with WIC and Immunizations to assure that, during the contact to set up a PCP assignment, that contact is used to provide other key health care information, related to smoking cessation, prenatal care, and well-child care and other preventive health issues.

4. HCS will be assisting recipients with dental appointments and case management.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				12.9	12.9
Annual Indicator			12.7	12.6	15.8
Numerator			3893	4159	5590
Denominator			30655	33008	35378
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	12.9	12	12	12	12

**Notes - 2007**

The majority of children receiving WIC services are preschool age children.

**Notes - 2005**

2004 data was used to estimate 2005 data.

**a. Last Year's Accomplishments**

The WIC program continued to provide nutrition assessments to eligible women and children and WIC food checks to purchase supplemental foods. The food package is already designed to assure adequate but not excessive levels of calories and fats, and encourages fruits, vegetables and whole grains.

WIC continued to administer the Farmer's Market Nutrition Program. Farmers' markets are an excellent source of fresh fruits and vegetables.

Cost containment has been implemented.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. The WIC Program recruits women and infants under 185% of poverty for nutritional assessment and counseling.	X			
2. WIC identifies children ages 0-2 as being at risk when either biological parent has a BMI > 30. WIC identifies children 2-5 as	X			

being at risk for overweight when the child has a BMI for age of > 85 percentile but < 95 percentile; children are consider				
3. The mothers and children are referred to nutritionists for initial counseling which includes assessment of food practices and exercise patterns.		X		
4. Increasingly, the WIC counselors are moving toward Value Enhanced Nutrition Advice (VENA) to encourage mothers and children to increase exercise in safe ways, and modify intake to reduce fats, enhance vegetables and fruit, and consume whole grains.		X		
5. These efforts are enhanced by the process initiated by Act 1220 of the state legislature, requiring schools (K-12) to measure BMI of all students each year, and report findings to the Arkansas Center for Health Improvement and parents.				X
6. In the second year of collecting this data, though % elevated BMI tended to rise until 9th or 10th grade, then diminish somewhat, same-person BMIs from one year to the next did not show an increase.				X
7. Community emphasis on proper nutritional environment in schools (vending machines, food services, etc.) and more safe recreational areas for exercise is growing all across the state because of this law and its initiative.				X
8.				
9.				
10.				

#### **b. Current Activities**

WIC will continue the activities described above.

WIC is currently developing policy and procedures to implement a new MIS "SPIRIT" which will integrate nutritional assessments, nutrition counseling and provision of food checks into a paperless operation.

Value Enhanced Nutrition Assessment (VENA) is being introduced to staff and being incorporated into participant assessments. VENA addresses individual client needs, nutritional status, and readiness to make behavior changes. All professional staff (nurses, nutritionists and home economists) completed two training sessions addressing skills for conducting client-centered, health outcome nutrition assessment: Counseling with both "I's Open- Language of Connection" and "Mining for Diamonds-Fun Way to Develop Critical Thinking Skills".

#### **c. Plan for the Coming Year**

Continuation of current services as described.

Implementation and training on the new MIS.

Implementation and training on VENA.

Assessment and drafting of new policy for the new WIC food package. The Interim Food Package Rule was released by USDA in December of 2007 with mandatory implementation by October 1, 2009. Arkansas is participating in several work groups to determine issues that must be addressed such as gathering product information from food manufactures, determining systems changes, and anticipating steps to implement.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				18.4	20.9
Annual Indicator			18.5	20.9	19.4
Numerator			6339	7552	7326
Denominator			34339	36160	37683
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	20.7	20.6	20.4	20.3	20.2

**Notes - 2007**

2007 data source is 2006 PRAMS survey.

**Notes - 2006**

2006 data source: 2005 PRAMS survey

**Notes - 2005**

This data is prepopulated with 2003 data, because a survey has not been completed since 2003.

**a. Last Year's Accomplishments**

ADH still actively utilizes the Stamp Out Smoking telephone line and fax back referral to provide smoking cessation assistance to clients. All clients seen in local health unit's maternity and family planning clinics are screened for tobacco use. This is a required question in the history and counseling components of the Women's Health programs. Women's Health Programs include up-to-date smoking cessation policies as ADH guidelines. The Public Health Nurse, ADH Nurse Practitioners and Clinicians utilize the UAMS ANGELS tobacco dependence/cessation guidelines for pregnant, postpartum and family planning clients.

Programs provide written information in English or Spanish on the risks of smoking and information on resources for cessation. ADH encounter management system (Business Objects) reported 1502 maternity clients (duplicated CY 2007) received smoking cessation education in the local health units. In addition, Business Objects reported that for CY2007 smoking cessation counseling/education was encountered for 3445 Family Planning visits, 6575 Family Planning Waiver visits and 943 STD visits. Clients receive education on the effects of tobacco/smoking in pregnancy and the identification of this as a preconception risk.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Pregnant women are asked at the initial visit and every subsequent visit about their smoking behaviors at DOH maternity clinics.		X		

2. The approach during the questioning is to follow the 5 "A"s.		X		
3. Should the patient show an interest in quitting, a motivational approach is followed in an attempt to define what steps she is willing to take to stop.		X		
4. Nearly all ADH nurse practitioners who provide prenatal care are advanced practice nurses, have a pharmacy privilege, and can order nicotine replacement therapy or other medications. ADH nurse practitioner protocols include clinical guidelines.		X		
5. The Stamp Out Smoking Quitline provides many tips and tricks for cessation and lists community based resources available to patients.			X	
6. The Stamp Out Smoking public awareness campaign appears on television during prime time in both the Little Rock and the Fayetteville/Ft Smith TV Markets. Many newspapers carry their ads.			X	
7. The Happy Birthday Baby Book and the Healthier Baby campaign also contain many suggestions about ways to quit smoking, and why. 8. Many sites in communities now have effective anti-smoking classes that display models and graphic drawings.				X
8. The BodyWalk demonstration project has been purchased for use in the state, and is frequently seen at health fairs and other events.			X	
9.				
10.				

#### b. Current Activities

The ADH screens all pregnant women for smoking. Smoking cessation education is offered in most ADH programs, i.e., Family Planning, WIC, and STD. Preconception counseling on smoking cessation is a focus in ADH's Family Planning clinics for women seeking pregnancy.

#### c. Plan for the Coming Year

Tobacco prevention and cessation education will continue to be provided in ADH public health clinics. Educational material will continue to be available for clients and providers through the ADH Tobacco Prevention and Education Program. Pamphlets in English and Spanish, a telephone hotline and the Stamp out Smoking internet site will continue to be available to assist in tobacco prevention and cessation education. Healthcare providers, along with individuals, organizations and others can now make referrals to Stamp out Smoking thru SOSWORKS. The program is funded through a contract with the Department of Health's Tobacco Prevention and Education Program. A fax back referral will link tobacco users to state tobacco cessation services. ADH clinicians, nurses, and staff will be able to provide information and referrals for all clients. Department of Health's clients in maternity clinics and other ADH clinics providing services to women and children will continue to be screened and counseled on tobacco usage at each visit.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	11.5	7	4.5	10	9
Annual Indicator	6.1	5.6	14.2	9.7	8.1
Numerator	12	11	28	19	16

Denominator	195281	195324	196748	196492	196492
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	8	7	6	6	6

#### Notes - 2007

2006 population estimate 15-19 years was used for 2007 rate.

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

#### Notes - 2006

Used 2005 population estimate 15-19 years for 2006 indicator.

#### a. Last Year's Accomplishments

In March, 2007, the Youth Suicide Prevention Task Force and the Attorney General's Office collaborated on a promotional event called "White Ribbon Week." A statewide conference on the topic was part of the week's events. Faculty from the UAMS Department of Psychiatry who participate on the Task Force's advisory committee presented a number of the conference workshops. Leading up to that conference, two pilot projects implementing a national model called "Teen Screen" reported their experiences and lessons learned. Although these pilot projects went well, the Task Force evaluated other models, and favored one that began in the state of Maine, a train-the-trainer program targeted to teachers and health professionals. The information covered the phenomenon of youth suicide, and helped teachers and health professionals become more aware of warning signs that a teen might be planning a suicide.

The Task Force recommended to the Department of Education that the Maine program be used in Arkansas. DOE provided administrative support for the Maine program to be "rolled out" in schools across the state.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. With Act 1757, the Arkansas Youth Suicide Prevention Act of 2005, the General Assembly established the Youth Suicide Prevention Task Force. That Task Force continues to be meet on a quarterly basis.				X
2. A mental health Advisory Council, made up of mental health and behavioral health professionals was set up to assist the				X

Youth Suicide Prevention Task Force. This group continues to be active.				
3. In March of 2008, the Attorney General again sponsored a "White Ribbon Week" with community activities at selected high schools in the state.				X
4. Prior to that conference, the "Teen Screen" model for public awareness was piloted at the Warren High School in Bradley County (Mississippi Delta), and at Catholic High School in Little Rock. The experiences and lessons learned in these projects we				X
5. Continuing with its work, the Youth Suicide Prevention Task Force evaluated and approved a program originally developed in the state of Maine, a train-the-trainer effort to raise awareness of teen suicide and its warning signs among teachers and heal				X
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Currently, various groups interested in the teen suicide issue are implementing the Maine program in communities across the state that expressed interest in participating. The Youth Suicide Task Force continues to meet and plan for further activities.

#### **c. Plan for the Coming Year**

Act 603 requires each school to appoint a Parent Facilitator to work directly with parents and the community. These activities will continue.

Anti-bullying programs and conflict resolution strategies are emphasized for application in schools.

The Youth Suicide Prevention Task Force has selected the Maine Youth Suicide Prevention program for recommended use throughout the school districts. This program suggests that each school have a "Gatekeeper" to help teachers and school health personnel to identify the warning signs of youth suicide that can be observed in students. This is a train-the-trainer intervention.

Student awareness of the relationship between drug and alcohol use and youth suicide will be enhanced.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	75.5	67	67	67	69
Annual Indicator	64.2	63.6	66.5	66.0	62.2
Numerator	376	463	451	479	483
Denominator	586	728	678	726	776
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	70	70	69	68	68

#### **a. Last Year's Accomplishments**

The ANGELS program worked actively on enhancing referrals of women in very early preterm labor and very low birthweight babies to Level III community hospitals and to UAMS Hospital. Guidelines for perinatal and neonatal screening and high risk care were continuously developed, discussed via a statewide telemedicine hookup, and disseminated to participating obstetricians and pediatricians on CDs. ADH maternity clinics continued to refer high risk pregnant women to UAMS for assessment and collaborative follow-up or referral. Private obstetricians and pediatricians continued to refer to UAMS. Telemedicine consults directly with doctors and their patients with maternal fetal medicine specialists at UAMS continue to grow in number.

The ANGELS program research evaluation matched birth records in the "before" time period to Medicaid Claims "Episodes of Pregnancy," and to hospital discharge records. The evaluation provides an extensive analysis of these baseline data. Meanwhile Episodes of Pregnancy data were compiled from Medicaid Claims for a two-year period of "after" data. Preliminary analysis suggested an observed increase in the number of referrals of extremely low weight infants to UAMS from communities over 80 miles distant from Little Rock.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Physicians, both OBGYNs and Family Physician Obstetricians deliver babies in most counties in the state.	X			
2. The ADH conducts prenatal clinics in 59 sites located in 54 of the 75 counties. Women's Health Nurse Practitioners are the clinicians, led by two physician specialists in OBGYN, one Board Certified in OBGYN. Approximately 4800 pregnant women are e	X			
3. The ANGELS program at the Department of OBGYN at UAMS provides telemedicine consultation to doctors and their patients for clinical questions related to pregnancy complications, and recommends maternal fetal medicine and neonatal subspecialty consult	X	X		
4. The ANGELS program also conducts weekly telemedicine conferences presenting interesting cases. These conferences are attended by OBs and pediatricians in all corners of the state, frequently having 30 or more attendees on a give morning. After case		X		X
5. ADH Women's Health Nurse Practitioners and Maternity Clinics receive these guidelines				X
6. Specialists at UAMS are also developing screener questionnaires for smoking, substance abuse, maternal depression, and other psycho-social risk factors.	X	X		X
7. The ANGELS research evaluation is beginning to provide detailed descriptions of the whole delivery and newborn care system in Arkansas and its response to guidelines and more available consultation and referral				X

8.				
9.				
10.				

#### **b. Current Activities**

The above features of the ANGELS project continue currently. Efforts to devise and test new questionnaires for maternal depression and smoking are still under way. In the evaluation, the "after" period of Medicaid Claims data has been collected into "Episodes of Pregnancy" and matched to birth certificates and hospital discharge records. Matching rates have again been very satisfactory. Extensive data analysis is now being carried out, and a number of publications are being planned.

Preliminary analyses have shown some interesting findings. For infants under 1000 grams, the number delivered at or referred to UAMS has increased more so than other weights and other facilities, especially for births to residents from communities greater than 80 miles distant from Little Rock. This is gratifying to the ANGELS effort. On the other hand, the percentage of births with birth weights in the ranges below 1500 grams and from 1500 to 2500 grams continues to grow. This finding has several implications for the data presented in this report. Consistent with this trend, and adding further explanation, is the finding that preterm birth rates, especially in the 34 to 37 month ages show the most prominent increases. The data above indicate an increase in the number of babies < 1500 grams delivered at an appropriate level of care, but a corresponding larger increase in the number of such babies born, reflects a decline in the percentage of those born at an appropriate level.

#### **c. Plan for the Coming Year**

If and when questionnaires for maternal depression, intimate partner violence, smoking and substance abuse are tested and available, ADH will be very interested in extending health department prenatal services to include these screeners.

The ANGELS evaluation has now obtained Medicaid Claims data for an "after" period following implementation of the ANGELS program start. Those data have been collected into "Episodes of Pregnancy" and matched to birth certificates and hospital discharge records with a very high match rate. Now both "before" and "after" data are available for analysis. The analytical process is now in "full swing." Multiple papers are planned. Initial poster session presentations show increases in referrals of babies under 1000 grams to UAMS NICUs, and significant cost savings because for these very sick babies, delivery in or referral to ICUs better treats serious medical complications, reduces hospital lengths of stay, and reduces cost.

Detailed investigations of the observed increased percentages of low and very low birth weight births, and preterm births, especially in the late preterm range are now being planned. These findings have also been observed in the ANGELS results.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	80.5	81	81	81	81
Annual Indicator	79.9	79.2	78.8	77.3	76.4
Numerator	29953	30200	30827	31065	31587
Denominator	37499	38130	39101	40203	41360
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82	82	82	82	82

#### **a. Last Year's Accomplishments**

The Arkansas Department of Health continued to support the Healthy Baby Happy Birthday Baby Book. Healthy Baby is a program of ADH that encourages all pregnant women to receive early and continual prenatal care. The Health Connections Section, through a ConnectCare contract with Arkansas Medicaid, worked to connect Arkansas Medicaid recipients to healthcare providers and health resources in their community. This is done by helpline operators who staff a telephone toll free helpline. The helpline operator's primary function is to assign Medicaid and ARKids recipients to a primary care physician and provide dental case management. They also respond to Medicaid and ARKids recipient questions and concerns, giving information, and offering guidance on accessing local health resources.

The Maternal and Child Healthline and Connect Care toll free telephone lines provided a resource for women in finding an obstetrician or pediatrician in their area. ADH has established an agency intranet resource directory site for the local health units. Resource information is available to the public thru a toll free telephone line.

The Department of Health continued the provision of maternity services in 61 Local health Unit sites in 55 counties. Local Health Units continue to work with their communities and providers to ensure pregnant women access to prenatal care. Clients are screened for presumptive eligibility Medicaid, provided referral information to providers and have access to other ADH services. The Local Health Units saw 4962 pregnant women for their initial prenatal appointments in CY 2007, 2703 patients were seen in their first trimester. ADH continues to reach the hard-to-reach populations of pregnant women. Women with socioeconomic issues such as poverty, substance abuse or domestic violence seek the non-judgmental care of the local health unit. Women's Health performed 14, 435 pregnancy tests for women who were pregnant or seeking pregnancy. Those women were offered prenatal or preconception counseling as per ADH policies.

The Perinatal Health Program oversees the Lay Midwife (LMW) Program. Currently, there are 31 Licensed Lay Midwives and 12 Lay Midwife Apprentices. The choice to use a lay midwife for home birth may provide a viable alternative to maternity care in Arkansas, particularly for low risk pregnant women. Local Health Unit's provide risk assessments and referrals, if needed for the LMW clients.

The Perinatal Program, ADH Women's Health Section, provided the semi-annual Maternity Training Program. This is a continuing education opportunity for Public Health Nurses, Maternal Infant Program Nurses and LPN's who are new to maternity services. This training is also offered as continuing education for Lay Midwives. In the four-day training, participants learn to take histories, identify high risk factors, provide education and counsel pregnant women, identify referral services. Experts in their fields present topics on pregnancy, smoking, infections, domestic violence, nutrition and more.

ADH continued to support and participates in the UAMS ANGELS activities, incorporating their guidelines into ADH policies. Activities include co-management of prenatal patients with UAMS Maternal Fetal Medicine (MFM), patient referrals to ANGELS, Telemedicine referrals, and prenatal genetic screening.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide public awareness campaigns are conducted multiple times each year, advertising the Healthier Baby Hotline and the importance of early prenatal care.		X	X	X
2. These public awareness "spots" frequently last 30 minutes to an hour and involve call-in opportunities for the public to put questions to an expert.		X	X	
3. The Healthier Babies webpage is always available. Newspaper articles are placed in a wide variety of local media to supplement TV markets, as some parts of Arkansas (the east and the south) depend on TV media markets located in Memphis TN, and Shreve		X	X	
4. The Happy Baby Birthday Handbook, available through the hotline and web page, contains parent educational materials for pregnancy and newborn care.		X		
5. The Happy Baby Birthday Handbook also contains coupons to be validated by the prenatal provider at each visit so that the women can receive discounts on products that are healthful for her and her baby.			X	
6. Prenatal Care is conducted in over 60 local health unit sites in 56 counties in Arkansas where that care is free or reduced cost. We have only charged a low "record maintenance fee" of \$3 to \$5, and it is not allowed to be a barrier.	X	X		
7. Local Health Unit clinics provide income estimation and perform presumptive eligibility for pregnant women, beginning their actual prenatal clinic care while formal Medicaid eligibility is established.		X		
8. Prenatal patients, once Medicaid covered, are referred to private sources of care at any time in pregnancy up to the onset of labor depending on the best referral relationship with other providers in each community.		X	X	
9.				
10.				

**b. Current Activities**

ADH continues to support the MCH Epidemiologist position. This allows for continued work on program evaluation, needs assessments, and analysis of common perinatal health indicators.

ADH continues to support and provide staff for the Campaign for Healthier Babies and the distribution of the Healthy Baby, Happy Birthday Baby Book, a coupon book designed as an incentive for pregnant women to obtain and continue prenatal care.

ANGELS is an important component of prenatal care in the LHU's. ADH Physicians continue to participate in the ANGELS teleconferences, and provide direction to ADH policies with the help of ANGELS evidence-based guidelines.

The PRAMS grant is used extensively for program planning and dissemination of information and data to public and private entities throughout Arkansas.

**c. Plan for the Coming Year**

Continue the MCH Epidemiologist position. ADH will continue to support and provide staff for the Campaign for Healthier Babies and the distribution of the Healthy Baby, Happy Birthday Baby Book.

Continue to support the semi-annual Maternity Training Program for public health nurses and other participants.

Continue support and participation with UAMS ANGELS (Antenatal Neonatal Guidelines for Education and Learning System). ADH physicians will continue to participate in the ANGELS teleconferences, and provide direction to ADH policies with the help of ANGELS evidence based guidelines.

The Family Health Branch will continue utilization of the perinatal and MCH information obtained through the PRAMS grant in program planning.

## D. State Performance Measures

**State Performance Measure 1:** *The percent of Arkansas high school students who have engaged in sexual intercourse.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	55			55	55
Annual Indicator	51.9	51.9	54	54	54.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	55	55	55	55	55

### Notes - 2007

Data source is 2007 national Youth Risk Behavior Survey.

### Notes - 2006

YRBSS is conducted in odd years. The 2005 survey results are reported for the 2006 indicator.

Arkansas has conducted many (10 this past year) community-based Abstinence Education projects. As many as 14 have been funded in past years. A behavioral-science evaluation of considerable scientific expertise (in our view) is showing that in these projects, students do respond to educational messages. Using a before-after self report methodology covering many thousands of students, those "exposed" to the educational "dose" report more favorable sexual values, beliefs, intentions, and behaviors at one year after the beginning of their educational "dose." However, when followed to 12 months after cessation of the "dose," their self-reported values, beliefs, intentions, and behaviors return to the levels of their "non-exposed" peers. This information was shared in a verbal report to the DOH (now ADH) leadership. A final report is awaited, and due in September 2007.

### Notes - 2005

This data is received from the Department of Education.

### a. Last Year's Accomplishments

Arkansas has funded many (10 this past year) community-based Abstinence Education projects. As many as 14, have been funded in past years. A behavioral-science evaluation of considerable

scientific expertise has been conducted. An Interim Phase V Report, provided May 2007, indicated initial improvements in attitudes and intentions in the pre-post tests after the abstinence education was received. However, twelve months after the intervention, these attitudes and intentions toward sexual activity essentially reverted back to where they were before they started the program. A Final Report is anticipated by July 14, 2008.

In 2006, 14 sub-grants were awarded to promote the growth of abstinence until marriage for ages less than 10 to 24 years. Sub-grants awards were made to school districts, faith, and community-based organizations. A total of 35,252 youth were served in 2006.

In 2007, funding was reduced for the sub-grants and the target population changed to youth ages 12 to 29 years.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide Family Planning clinics in all counties.	X			
2. Community based outreach efforts to recruit to FP clinics done in some counties.		X		
3. Abstinence Education Program makes competitive grants to lead agencies in 8 communities to mount "abstinence only" education programs to reduce teen sex.		X		
4. Technical assistance has been provide for sub-grantees.		X		
5. The Institute for Research and Evaluation will complete Phase V Final Report.		X		
6. In 2006, 14 sub-grants were awarded to promote the growth of abstinence until marriage for ages less than 10 to 24 years. A total of 35,252, youth were served in 2006.		X		
7.				
8.				
9.				
10.				

#### **b. Current Activities**

There are currently 8 sub-grants awarded to schools, faith, and community-based organizations throughout the state. The Institute for Research and Evaluation will submit a Phase V Final Report on the FY 2007 grant activities in July 2008.

#### **c. Plan for the Coming Year**

The Request for Application to award sub-grants to schools, faith, and community-based organizations, using the state appropriated funds, was released in April 2008, and 7 sub-grants were selected by the Grant Review Committee. The program is waiting for notice about availability of Federal funding after June 30, 2008. The program is expecting communication from the Governor's office on appointments to the Steering Committee on Abstinence Education.

**State Performance Measure 2:** *The percentage of children through age 18 and below 200 percent of poverty enrolled in ARKids First child health insurance program.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective	24	18	18	85	35
Annual Indicator	17.3	83.3	85.6	29.9	30.5
Numerator	65789	290170	290170	102997	105097
Denominator	381000	348257	339000	344161	344161
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	35	35	36	36	36

#### Notes - 2007

2006 population estimate 0-18 used for 2007 indicator

#### Notes - 2006

Population below 200 percent of poverty data source: US Census Bureau.

ARKids First Enrollment data source: DHS Medicaid Program. This is an unduplicated count.

As of 7-15-07, we are still trying to confirm this information. It is not consistent either with earlier data, nor with evidence that AR Kids First continues to serve more children in Arkansas.

#### Notes - 2005

Prepopulated. Data not available this year.

#### a. Last Year's Accomplishments

1. The Health Connections Section (HCS) now covers health information services not necessarily funded by the Medicaid ConnectCare contract. The Medicaid ConnectCare contract includes PCP assignment and dental managed care. Additional programs in HCS include health information support for prenatal care (Campaign for Healthy Babies), smoking cessation (Clean Indoor Air), and information related to WIC, Immunizations and many other services.

2. HCS health education staff visited communities, Head Start services, schools and day care centers to find potentially eligible children and get them enrolled as well as assist in health information needs and resource development.

3. HCS staff operated the Arkansas Health Information helpline on an 8:00 am to 4:30 pm basis five days a week, providing information on accessing services in general. Information on a wide variety of community sources of care is shared with callers, to connect them to all health resources, including Medicaid.

4. HCS staff, funded through the Medicaid ConnectCare contract, operated the ConnectCare helpline from midnight on Sunday through midnight on Friday to help callers apply for Medicaid benefits, and to help enrolled recipients to obtain a primary care physician.

5. Over the past several years, Medicaid has streamlined the application processes for families to get their children on AR Kids A & B programs.

6. Public awareness activities in mass media included newspaper clips and TV spots.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Public awareness announcements through Connect Care and advertising AR Kids A and B programs			X	
2. IDs for enrolled children are shared with the Family Health Branch's Health Connections Section. Newly enrolled clients or the child client's parent are contacted to set up a first primary		X		

care provider visit.				
3. Ongoing hotline support for all enrollees with questions. Clients frequently request transfers to another provider.			X	
4. Health educator visits to Head Start child care programs to assist with getting kids referred to both medical and dental care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

1. Activities listed in items 1-6 continue this year.

2. HCS has been developing its ConnectCare contract with medicaid to establish more positions for the ConnectCare helpline to link Medicaid recipients to primary care physicians and dentists throughout the state.

3. HCS is developing its role as a resource to support Human Service Workers in schools to assure that students are healthy and ready to learn. Access to a wide variety of services for students will be enhanced including Medicaid, mental and dental health, and other social and health services.

#### **c. Plan for the Coming Year**

1. HCS will continue to undertake the above activities.

2. HCS will implement the effort to link Medicaid recipients with dentists' offices.

3. HCS will look for other ways in which to improve recipient and potential recipient knowledge and skills in using the health care system.

4. HCS will be assisting recipients with dental appointments and case management.

#### **State Performance Measure 3: *The percent of pregnant women counseled for HIV testing.***

##### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	75	75	75	0	0
Annual Indicator	69.1	64.5	67.4	67.4	67.0
Numerator	24074	22704	23760	23760	24604
Denominator	34826	35212	35276	35276	36724
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	68	69	70	71	72

#### **Notes - 2007**

2007 data source is 2006 PRAMS survey.

#### **Notes - 2006**

Data source: 2005 Arkansas PRAMS survey.

2006 cells populated with 2005 PRAMS numbers.

Breast feeding awareness and counselling efforts are now administratively co-located with WIC, and managed by that Branch. Their statewide efforts continue. There has been a steady upward trend in breastfeeding in Arkansas, so we would expect the next PRAMS survey carrying these questions to reveal no decrease.

#### Notes - 2005

Data source: 2005 Arkansas PRAMS survey.

#### a. Last Year's Accomplishments

ADH provided maternity services in 61 Local health Unit sites in 55 counties. Local Health Units continue to work with their communities and providers to ensure pregnant women access to prenatal care. Clients are screened for presumptive eligibility Medicaid, provided referral information to providers and have access to other ADH services. The Local Health Units saw 4962 pregnant women for initial prenatal appointments in CY 2007. ADH continues to reach the hard-to-reach populations of pregnant women. Women with socioeconomic issues such as poverty, substance abuse or domestic violence seek the non-judgmental care of the local health unit. Prenatal patients are screened for HIV unless they opt out of the test. Prenatal patients must be provided counseling to determine any risk factors for HIV (Pre-test HIV counseling) even if they opt out of the test. Post Test counseling is also provided. Clients with risk factors are re-screened during their pregnancy, if applicable.

ADH clinical policies include a maternity education class for its prenatal patients on sexually transmitted diseases.

ADH Business Objects report that 4289 HIV (serum and rapid oral swab HIV tests) tests were performed at an initial maternity visits. An additional 1344 HIV tests were performed at subsequent or other maternity visits, which would be duplicated clients. UAMS continues to be the referral source for women testing positive for HIV during pregnancy.

Family Planning clients are routinely offered HIV counseling and testing, this can facilitate identification of risk factors and of women testing positive for HIV prior to pregnancy. ADH Business Objects reported that 24,841 family planning clients received HIV testing in CY 2007.

HIV testing to provided in all Local Health Units, even those not providing Women's Health services such as Maternity and Family Planning.

The HIV/STD Section continues to provide outreach education and HIV testing throughout the state. Business Objects reported in CY 2007 the ADH HIV/STD program tested 16,195 clients (duplicated, men and women).

UAMS ANGELS continued to receive the referrals for women testing positive for HIV.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All pregnant women seen at ADH local health units are counseled about the advisability of having an HIV test during this pregnancy.	X	X		
2. Local health units served 5,726 women by providing HIV counseling and tests, (counting both prenatal and post-natal care services).	X	X		
3. State law requires all obstetrical care providers to offer and HIV test to their pregnant patients. Patients, in this legislation,				X

may "opt out" of the testing.				
4. Public awareness announcements about HIV and AIDS continue to be aired on the state's television channels.			X	
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The Department of Health provides prenatal care which includes physical assessments, laboratory testing, genetic screening and counseling, prenatal education, nutritional counseling and education, WIC services, and referrals as indicated for high risk care. The ADH provides prenatal care in 55 counties at 61 local public health units. An HIV Counseling course provides training to ADH colleagues who provide HIV counseling and testing services. HIV antibody counseling and testing is routinely performed in ADH local health unit clinics where services are provided to men and women. Counseling and testing services are strongly encouraged for persons with HIV exposure risks or risk behaviors. For clients receiving rapid HIV tests, HIV Prevention Counseling Risk Reduction Plan is initiated and updated with each visit related to the rapid test.

#### **c. Plan for the Coming Year**

ADH will continue to provide direct patient care services. Voluntary, confidential HIV counseling and testing will continue to be provided by ADH. HIV testing has been expanded to include rapid HIV tests for clients with HIV exposure risk factors. Colleagues will attend the HIV counseling course to provide effective prevention counseling and risk reduction plans for patients. Arkansas has an "Opt Out" legal requirement that pregnant women be tested for syphilis, Hepatitis B, and HIV, or required documented refusal by the patient. ADH will continue to counsel and instruct pregnant women about HIV and prevention for the unborn infant.

ADH Women's Health programs will continue to participate in the activities and work of the HIV/STD Program.

**State Performance Measure 4:** *Percentage of children receiving WIC services who are above the 95th percentile on the National Center for Health Statistic weight for height growth charts.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	7	6	5	5	5
Annual Indicator	10.8	10.8	10.7	11.2	11.2
Numerator	8060	8060	7876	8781	9553
Denominator	74630	74630	73610	78402	85295
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	11.5	11.3	11.1	11	10.8

#### **Notes - 2007**

Data are from the PEDNSS report provided by CDC.

#### **Notes - 2006**

Data are from the PEDNSS report provided by CDC.

The increase in percentage of WIC kids over 95th percentile is noted. This is across all WIC ages, but that group is heavily concentrated with kids at or below school age.

Arkansas has been working intensively on an obesity prevention project carried out in all schools in the state, now both public and private. The state is measuring BMI with usable reports on over 300,000 school children per year, mostly from kindergarden to 12th grades, with larger school districts reporting on pre-K also. Having tracked these children for the third year, we are seeing no increase in the percentage of children in the overweight and at-risk-for-overweight categories. In fact a slight decline was evident in comparing the last two years' data.

We believe, looking at YRBS data over several decades, that there is a great deal of "momentum" toward a continuing rise in percentages of overweight and at-risk children. So any leveling of this trend seems hopeful.

As Arkansas's school-based obesity awareness campaign informs families of their children's health, it is at least theoretically possible that this education will result in improvements in diet and activity for younger children in these families. The National Performance Measure related to WIC children 2-5 looks at this in a more refined way.

#### **a. Last Year's Accomplishments**

The increase in percentage of WIC children over 95th percentile is noted. This is across all WIC ages, but that group is heavily concentrated with children at or below school age.

Arkansas has been working intensively on an obesity prevention project carried out in all schools in the state, now both public and private. The state measured BMI with usable reports on over 300,000 school children per year, mostly from kindergarten to 12th grades, with larger school districts reporting on pre-K also. Having tracked these children for the fourth year, no increase was seen in the percentage of children in the overweight and at-risk-for-overweight categories. In fact a slight decline was evident in comparing the last three years' data.

Looking at YRBS data over several decades, it appears that there is a great deal of "momentum" toward a continuing rise in percentages of overweight and at-risk children. So any leveling of this trend seems hopeful.

As Arkansas's school-based obesity awareness campaign informs families of their children's health, it is at least theoretically possible that this education will result in improvements in diet and activity for younger children in these families. The National Performance Measure related to WIC children 2-5 looks at this in a more refined way.

ADH continued to provide nutritional assessments, dietary advice and food instruments to WIC participants.

ADH continued to provide Farmer's Market Nutrition Program (FMNP) coupons in participating counties.

All WIC Competent Professional Authority (CPA) staff have received Value Enhanced Nutrition Assessment (VENA) training.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WIC Program recruits women and infants under 185% of	X			

poverty for nutritional assessment and counseling.				
2. WIC identifies children ages 0-2 as being at risk when either biological parent has a BMI > 30.	X			
3. WIC identifies children 2-5 as being at risk for overweight when the child has a BMI for age of > 85 percentile but < 95 percentile; children are consider overweight when the child has BMI for age of > 95th percentile.		X		
4. The mothers and children are referred to nutritionists for initial counseling which includes assessment of food practices and exercise patterns.		X		
5. Increasingly, the WIC counselors are moving toward Value Enhanced Nutrition Advice (VENA) to encourage mothers and children to increase exercise in safe ways, and modify intake to reduce fats, enhance vegetables and fruit, and consume whole grains.		X		X
6. These efforts are enhanced by the process initiated by Act 1220 of the state legislature, requiring schools (K-12) to measure BMI of all students each year, and report findings to the Arkansas Center for Health Improvement and parents.				X
7. In the second year of collecting this data, though % elevated BMI tended to rise until 9th or 10th grade, then diminish somewhat, same-person BMIs from one year to the next did not show an increase.				X
8. Community emphasis on proper nutritional environment in schools (vending machines, food services, etc.) and more safe recreational areas for exercise is growing all across the state because of this law and its initiative.				X
9.				
10.				

#### **b. Current Activities**

WIC will continue the activities described above.

WIC is currently developing policy and procedures to implement a new MIS "SPIRIT" which will integrate nutritional assessments, nutrition counseling and provision of food checks into a paperless operation.

Value Enhanced Nutrition Assessment (VENA) is being incorporated into participant assessments. VENA addresses individual client needs, nutritional status, and readiness to make behavior changes. All professional staff (nurses, nutritionists and home economists) completed two training sessions addressing skills for conducting client centered, health outcome nutrition assessment: Counseling with both I's Open- Language of Connection" and "Mining for Diamonds-fun Way to Develop Critical Thinking Skills"

#### **c. Plan for the Coming Year**

Continuation of current services as described.

Implementation and training on the new MIS

Implementation and training on VENA.

Assessment and drafting of new policy for the new WIC food package. The Interim Food Package Rule was released by USDA in December of 2007 with mandatory implementation by

October 1, 2009. Arkansas is participating in several work groups to determine issues that must be addressed such as gathering product information from food manufactures; determining systems changes; anticipating steps to implement.

**State Performance Measure 5:** *To improve the percent of 14 to 15 year olds on Children's Medical Services (CMS) who state that CMS transition services have helped improve their knowledge and ability to transition into adult life.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	6	7	8	9	10
Annual Indicator	8.5	7.9	7.9	5.5	21.7
Numerator	57	3	3	10	15
Denominator	669	38	38	182	69
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	22	23	24	25	26

**Notes - 2007**

This data was supplied from responses on our statewide survey done in early 2008 on Transition and program assistance provided by the states' Title V CSHCN staff.

**Notes - 2006**

There was no Parent Satisfaction survey sent this year.

This data was supplied with information collected on the 2006 CSHCN Transition Survey.

**Notes - 2005**

There was no Parent Satisfaction survey sent this year. However, data from the Transition Survey indicates that the level of involvement with CMS staff related to individual teen's transition issues has not increased.

**a. Last Year's Accomplishments**

SPM 05 Last Year's Accomplishments

Mail-out of a transition focused survey to youth on the CSHCN database in the month of their 14th birthday. A program display has been set-up around the state at Transition Fairs hosted by the Local Education Cooperatives. The Title V Parent Coordinator completed the development of Transition Tip Sheets to be used by staff when working with YSHCN and with the aforementioned display. CSHCN caseworkers assist families and YSHCN to apply for the DDS Alternative Community Services Home and Community Based Waiver.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Transition surveys were received from 125 young people with responses that assist our program in planning services for the individual.		X		
2. Participate in AR Interagency Transition Partnership with Dept of Ed, Higher Ed, Disability Rights, Rehab Services and DHS agencies serving adolescents and young adults (DDS, Children & Family Services, Behavioral Health, & Youth Services).				X

3. Work with individual YSHCN and local transition representatives to develop transition plans.	X			
4. CSHCN staff work with local councils to staff Transition Fairs in the Dept of Education's regional Local Education Cooperatives. The fairs are attended by youth throughout several school districts who are served by Special Education and 504.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

##### **SPM 05 Current Activities**

The program continues to send the Transition Survey to YSHCN in the month of their 14th birthday. Survey responses indicating a problem or a need for assistance are forwarded to the CSHCN caseworker. CSHCN caseworkers make individual contact with individuals on their case management caseload re: transition needs. Newsletter articles provide information on transition issues to a larger forum. CSHCN caseworkers assist individuals with developmental disabilities in application for the DDS Alternative Community Services Home and Community Based waiver.

#### **c. Plan for the Coming Year**

##### **SPM 05 Plan for the Coming Year**

In addition to ongoing efforts in transition, training targeted toward transition objectives, resources and issues is planned for the CSHCN staff in September 2008.

**State Performance Measure 6:** *Improve percent of parents responding to the question on Children's Medical Services (CMS) Parent Satisfaction Survey that CMS service coordination teams told them about other services available.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	54	57	61	63	65
Annual Indicator	48.3	51.9	51.9	51.9	55.7
Numerator	323	28	28	28	151
Denominator	669	54	54	54	271
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	52	53	54	55	58

#### **Notes - 2007**

This data was compiled from responses to our statewide surveys sent out in early 2008.

#### **Notes - 2006**

A Parent Satisfaction survey was not sent out this year; however, anecdotal evidence (audit review of casework and programs, telephone contact with families by management staff, etc) indicates that the data collected in the 2004 survey has not changed substantially.

#### Notes - 2005

A Parent Satisfaction survey was not sent out this year; however, anecdotal evidence (audit review of casework and programs, telephone contact with families by management staff, etc) indicates that the data collected in the last survey has not changed substantially.

#### a. Last Year's Accomplishments

##### SPM 06 Last Year's Accomplishments

CSHCN staff is responsible for job tasks related to several programs. Among them: the Title V CSHCN Family Support/Respite program, applications for the DDS programs (Waiver, Special Needs, and Integrated Supports.) Referrals for these programs/services are made on a regular basis to assure that families of CSHCN receive needed services. Referrals are also made to other DHS and interagency programs such as: Together We Can and CASSP.

Upon initial evaluation of applications, caseworkers make referrals for WIC, income based Medicaid, Food Stamps, disability-based Medicaid such as SSI and TEFRA and the Part C program for Early Intervention services. Referrals are also made for medical care or evaluations by specialists such as Habilitation specialists in regional clinics or developmental evaluations by interdisciplinary teams. Referrals are also made for Title V CSHCN coverage for the purchase of items not covered by Medicaid, such as wheelchair ramps, ceiling lifts and van lifts to provide a measure of relief to caregivers.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide assistance in application for short-term emergency assistance from private and public programs.	X			
2. Referral and assistance in applying for long-term wrap-around services, such as the DDS Waiver.	X			
3. Referral and assistance in applying for short-term wrap-around services.	X			
4. Upon request from parent/guardian, staff will assist with referral and application for residential treatment services.	X			
5. Provide assistance in accessing funding via Title V CSHCN program for equipment or services not covered by Medicaid.	X			
6. Work in conjunction with other programs (public and private) to provide resources and assistance to families of dually diagnosed children in crisis.		X		
7. Referral for Part C Early Intervention services.		X		
8.				
9.				
10.				

#### b. Current Activities

##### SPM 06 Current Activities

All except two of the CSHCN caseworkers are now relieved of Part C job tasks. This has improved the ability of staff to make more consistent care coordination for families. The CSHCN caseworkers continue to be responsible for the day-to-day activities of both Title V and DDS

programs.

The Title V Family Support/Respite Program has provided financial assistance to 158 families since November 2007. The Title V CSHCN program has paid for services that were ineligible for Medicaid coverage for 146 children and youth. Examples of these services include Medical Camp costs, Van Lifts, Wheelchair ramps, Overhead lifts, and PKU Foods.

### c. Plan for the Coming Year

SPM 06 Plan for the Coming Year

Increase training for CSHCN staff to provide tools for their use while working with families. No changes are planned other than the completion of transitioning all Title V CSHCN care coordinators from the Part C job tasks.

**State Performance Measure 7:** *The percent of public school students overweight greater than 95th percentile.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	11	11	9	7	5
Annual Indicator	22.0	21.0	20.8	20.5	20.6
Numerator	60953	72636	77351	75596	75544
Denominator	276783	345892	371367	369416	366801
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	20.4	20.2	20	19.8	19.6

#### Notes - 2007

Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Four (Fall 2006 - Spring 2007).

Beginning in 2007, BMI measurements are done for every other grade - even grades from Kindergarten through grade 10. Some schools with pre-K programs are assessing these children as well.

The 2006 notes are in error regarding tracking of the same students year to year. Rather percentages are based on individual grades each year.

#### Notes - 2006

Source: Arkansas Center for Health Improvement: The Arkansas Assessment of Childhood and Adolescent Obesity - Tracking Progress: Online Report 3 (Fall 2005 - Spring 2006).

These data show a level, or slightly declining, trend in the percentage of students who are overweight. That finding occurs in a major statewide study measuring BMI in as many as 371,000 students. This number represents a strong majority of the approximately 400,000 K-12 students in Arkansas. The BMI measurements are taken in schools, and communicated to parents confidentially in a letter. The measurement has been done for each student each year (where we are able), so Arkansas can track individual students from one year to the next. The stable or slightly declining trend in the percentages of both overweight and at-risk-for-overweight children is measured in the same students from one year to the next. That these percentages are not increasing, and perhaps even showing a slight decline, is a very important finding.

That these studies were done in schools and on all kids (as many as possible) has made this effort a major community-based project about which there has been a great deal of publicity and dialogue. The project is being assessed by a research evaluation conducted by the College of Public Health at UAMS. So far, surveys of parents has returned little complaint about how their child's information was handled. So far the results regarding behaviors of students and families regarding nutrition and physical activity has shown less clear impact, but these changes on self-report may take more time to reveal.

#### **Notes - 2005**

Source: Arkansas Center for Health Improvement.

##### **a. Last Year's Accomplishments**

The Arkansas Center for Health Improvement (ACHI) completed its fourth year of managing and leading the collection of student BMI assessments for the state. The tasks involved in conducting this work were divided into two separate but related realms of work:

- 1) The first involved the collection of data by school nurses and its entry into a web-based system that calculated the child's BMI, automatically generated a customized letter to the parent, and compiled the student data by school district. While seemingly a simple process, the collection methodology had been fine tuned over time to reduce reliance on paper, expedite return of BMI assessments and ensure proper notification to parents. The process has been developed to respect strict limitations and/or assurances that allow the data to be used in on-going disease surveillance, while ensuring student health records remain confidential.
- 2) The second realm of work was the storage and management of the world's largest database of individual records of child BMI. The database has grown and is now available as a rich source of information for research on obesity identification and control.

Schools continued to make significant progress in:

- 1) Modifying food environments so that vending machines became less available to grade school students, and machines in high school were closed until after the last lunch period. Even then, products served in those machines were required to have healthy offerings for at least half of the choices, and not over-priced compared to other commercial products.
- 2) Increasing physical activity in schools by advancing to active play in physical education classes and in recess.  
A minimum guideline of 150 minutes per week for junior high students was set.
- 3) Increasing reviews by Wellness Committees in each school district to assess the school health environment, using a CDC-developed tool called the School Health Index, and to promote policy and activities increasing public awareness of proper nutrition and exercise.

Last year was very successful for Coordinated School Health (CSH) as well.

The 2006/2007 school year CSH school sites strengthened the wellness committees and began implementing activities to reduce obesity in staff and students. Examples of activities of the 11 school sites are staff workout rooms, wellness 'fests', walking contests, bike giveaways (with health education instruction provide), recess with a purpose and many others. These activities are chosen and implemented on a local level so the variety is vast and the communities are engaged. Led by the Core Team, the state level CSH provided these sites with quarterly trainings including information regarding quality available resources, many which were free or low cost.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Act 1220 established a statewide program to address obesity in children creating the Child Advisory Committee, and proving for new regulation of schools to improve nutrition and physical activity.				X
2. Statewide, all school children have had their body mass index measured in a way that respects privacy, and had the results forwarded confidentially to their parents with advice about a necessity to follow-up with a doctor.			X	
3. Statewide, new regulations have removed food vending machines from all grade schools, and in high schools, have allowed machine sales during the day only after the last period when lunch is served.				X
4. Nutritional content requirements for vended foods are now in place requiring healthy choices.				X
5. School districts are required to have a Wellness Committee to assess the school environment for many health issues and make recommendations.				X
6. Grants were awarded to the 31 CSHP model school districts.		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2007, the Arkansas Department of Education, Office of Coordinated School Health and the Arkansas Department of Health, Office of Tobacco Prevention and Cessation entered into a collaborative partnership to provide funding to twenty-three additional schools districts through Tobacco Prevention - CSH Grants. This brings the total number of number of school districts participating in the CSH program to 31.

**c. Plan for the Coming Year**

CSH initiative plans to continue working with the current CSH sites, providing quarterly training and ongoing technical assistance. This year CSH will develop a strategic statewide marketing plan with the action team and explore the feasibility of School-based health centers.

**State Performance Measure 8:** *The percentage of at-risk for overweight children in Arkansas public schools.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	11	11	9	7	5
Annual Indicator	17.7	17.2	17.2	17.1	17.2
Numerator	49016	59503	63943	63315	63059
Denominator	276783	345892	372369	369416	366801
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	17.1	17	16.8	16.7	16.6

**Notes - 2007**

Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Four (Fall 2006 - Spring 2007).

**Notes - 2006**

Source: Arkansas Center for Health Improvement, Fall 2005 - Spring 2006.

This level, or slightly declining trend regarding at-risk for overweight children in schools is noted. Please see comments in field notes for the measurements of the overweight group.

**Notes - 2005**

Source: Arkansas Center for Health Improvement, Fall 2004 - Spring 2005.

**a. Last Year's Accomplishments**

The Arkansas Center for Health Improvement (ACHI) completed its fourth year of managing and leading the collection of student BMI assessments for the state. The tasks involved in conducting this work were divided into two separate but related realms of work:

- 1) The first involved the collection of data by school nurses and its entry into a web-based system that calculated the child's BMI, automatically generated a customized letter to the parent, and compiled the student data by school district. While seemingly a simple process, the collection methodology had been fine tuned over time to reduce reliance on paper, expedite return of BMI assessments and ensure proper notification to parents. The process has been developed to respect strict limitations and/or assurances that allow the data to be used in on-going disease surveillance, while ensuring student health records remain confidential.
- 2) The second realm of work was the storage and management of the world's largest database of individual records of child BMI. The database has grown and is now available as a rich source of information for research on obesity identification and control.

Schools continued to make significant progress in:

- 1) Modifying food environments so that vending machines became less available to grade school students, and machines in high school were closed until after the last lunch period. Even then, products served in those machines were required to have healthy offerings for at least half of the choices, and not over-priced compared to other commercial products.
- 2) Increasing physical activity in schools by advancing to active play in physical education classes and in recess. A minimum guideline of 150 minutes per week for junior high students was set.
- 3) Increasing reviews by Wellness Committees in each school district to assess the school health environment, using a CDC-developed tool called the School Health Index, and to promote policy and activities increasing public awareness of proper nutrition and exercise.

Last year was very successful for Coordinated School Health (CSH) as well.

The 2006/2007 school year CSH school sites strengthened the wellness committees and began implementing activities to reduce obesity in staff and students. Examples of activities of the 11 school sites are staff workout rooms, wellness 'fests', walking contests, bike giveaways (with health education instruction provide), recess with a purpose and many others. These activities are chosen and implemented on a local level so the variety is vast and the communities are engaged. Led by the Core Team, the state level CSH provided these sites with quarterly trainings including information regarding quality available resources, many which were free or low cost.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service
------------	--------------------------

	DHC	ES	PBS	IB
1. Act 1220 established a statewide program to address obesity in children creating the Child Advisory Committee, and proving for new regulation of schools to improve nutrition and physical activity.				X
2. Statewide, all school children have had their body mass index measured in a way that respects privacy, and had the results forwarded confidentially to their parents with advice about a necessity to follow-up with a doctor.			X	
3. Statewide, new regulations have removed food vending machines from all grade schools, and in high schools, have allowed machine sales during the day only after the last period when lunch is served.				X
4. Nutritional content requirements for vended foods are now in place requiring healthy choices.				X
5. School districts are required to have a Wellness Committee to assess the school environment for many health issues and make recommendations.				X
6. Grants were awarded to the 31 CSHP model school districts.		X		
7.				
8.				
9.				
10.				

#### **b. Current Activities**

In 2007, the Arkansas Department of Education, Office of Coordinated School Health and the Arkansas Department of Health, Office of Tobacco Prevention and Cessation entered into a collaborative partnership to provide funding to twenty-three additional schools districts through Tobacco Prevention - CSH Grants. This brings the total number of number of school districts participating in the CSH program to 31.

#### **c. Plan for the Coming Year**

CSH initiative plans to continue working with the current CSH sites, providing quarterly training and ongoing technical assistance. This year CSH will develop a strategic statewide marketing plan with the action team and explore the feasibility of School-based health centers.

#### **State Performance Measure 9: *The percent of women smoking during pregnancy.***

##### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	15	15	13	11	11
Annual Indicator	20.3	20.3	16.2	16.0	15.7
Numerator	7069	7069	6370	6539	6441
Denominator	34825	34825	39210	40962	41065
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	15	14.8	14.4	14	13.5

#### **Notes - 2007**

Source: Health Statistics Branch - Birth Certificates

#### **Notes - 2006**

Source: Health Statistics - 2006 Birth Certificates

While smoking data on birth certificates may be somewhat under-reported, the under-reporting seems pretty consistent across states, demographic groups, and years. This apparent small decline is consistent with the ANGELS program's developing services to help pregnant women quit. The ANGELS hotline provides community-based resource information to women who call in with this question. In addition, ANGELS has included in its clinical guidelines, and therefore underscores the issue with providers, the importance of quitting. Additionally, ANGELS is developing a questionnaire to be used in prenatal clinics and at preconceptional health visits to help more accurately assess for smoking behaviors. So far, ADH is awaiting the completed validation of the questionnaire before using them more widely in our prenatal and family planning clinics.

#### Notes - 2005

Source: Health Statistics - 2005 Birth Certificates

#### a. Last Year's Accomplishments

ADH actively utilizes the Stamp Out Smoking telephone line and fax back referral to provide smoking cessation assistance to clients. All clients seen in local health units are screened for tobacco use (Family Planning, Maternity, STD, WIC, TB). This is a required question in the history and counseling components for the Women's Health and WIC programs. Women's Health Program's include up-to-date smoking cessation policies as guidelines. The Public Health Nurse, ADH Nurse Practitioners and Clinicians utilize the UAMS ANGELS tobacco dependence/cessation guidelines for pregnant, postpartum and family planning clients. Programs provide written information in English or Spanish on the risks of smoking and information on resources for cessation. ADH encounter management system (Business Objects) reported that 1502 maternity clients (duplicated CY 2007) received smoking cessation education in the local health units. In addition, Business Objects reported that for CY2007 smoking cessation counseling/education was encountered for 3445 Family Planning visits, 6575 Family Planning Waiver visits and 943 STD visits. Clients receive education on the effects of tobacco/smoking in pregnancy and the identification of this as a preconception risk.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pregnant women participating in the ADH Prenatal Clinics and WIC clinics are asked at the initial prenatal visit and every subsequent visit about their smoking behaviors.	X	X		
2. The questioning approach follows the "5 As" model.	X	X		
3. Where patient interest in quitting is encountered, a motivational counseling effort is undertaken, and women are referred to the Fax Back aspect of the Quitline, which is still very active in Arkansas.	X	X		
4. All women's health Advanced Practice Nurses who have pharmacy privileges (the large majority) have protocols for smoking cessation including guidelines cessation treatments such as nicotine replacement.		X		
5. The Happy Birthday Baby Book is provided free to all pregnant women who request it. It has advice about techniques and tricks to quit. It also identifies resources for their assistance, including the availability of nicotine replacement therapies.		X		
6.				
7.				
8.				

9.				
10.				

#### **b. Current Activities**

ADH is actively utilizing the Quitline (formerly the Stamp Out Smoking line) telephone line and fax back referral to provide smoking cessation assistance to clients. Clients are being provided with smoking cessation education and written materials in the local health units. Plans are being made for a new stakeholder discussion group to outline additional activities that could be pursued in the coming years.

#### **c. Plan for the Coming Year**

Tobacco prevention and cessation education will continue to be provided in ADH public health clinics. Educational material will continue to be available for clients and providers through the ADH Tobacco Prevention and Education Program. Pamphlets in English and Spanish, a telephone hotline and the Stamp out Smoking internet site will continue to be available to assist in tobacco prevention and cessation education. Healthcare providers, along with individuals, organizations and others can now make referrals to the Stamp out Smoking thru SOSWORKS. The program is funded through a contract with the Department of Health's Tobacco Prevention and Education Program. A fax back referral will link tobacco users to state tobacco cessation services. ADH clinicians, nurses, and staff will be able to provide information and referrals for all clients. ADH clients in maternity clinics and other ADH clinics providing services to women and children will continue to be screened and counseled on tobacco usage at each visit.

**State Performance Measure 10:** *To increase the percentage of ADH Family Planning clients receiving nutritional counseling during an initial or annual visit in the Family Planning clinics.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				0	80
Annual Indicator		61.5	73.7	75.6	84.0
Numerator		31784	36537	35779	38439
Denominator		51704	49582	47341	45770
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	86	87	88	89	90

#### **Notes - 2007**

Source is Business Objects: family planning encounters that reported Nutritional Counseling-non WIC and 34 Nutrition assessments.

#### **Notes - 2006**

The Performance Measure was changed to reflect data that we are presently able to collect. Plans for the future are to advocate for the collection of data in the Information Management System for BMI, counseling on BMI and if the patient was overweight.

Numerator and denominator are from the Information Management System.

The Family Health Branch is now working toward a strategic planning dialogue with "sister" Branches in the Center for Health Advancement to consider the issue of preconceptional counseling. We are broadening this concept to include pre- and inter-conceptional counseling in a broader-based program of Women's Health counseling. Arkansas's Healthy Arkansas Campaign has already produced solid gains in computer-based risk assessment and physical exercise challenges conducted in the Department of Health as an employer, in Blue-Cross/Blue

Shield as an employer, and now an additional 60 or so other firms throughout the state. We have therefore, already begun an effort to find women in the workplace. By adding the details of a preconceptional or interconceptional health risk appraisal to the general health appraisal already conducted regarding nutrition and physical activity, it seems plausible that a broader Women's Health Counseling campaign could be developed in Arkansas. The next opportunity for widening the approach to women of reproductive age, may lie in collaborative efforts with schools, chronic disease programs, smoking cessation programs, and WIC, not to mention Maternity and Family Planning Clinics across the state.

#### **a. Last Year's Accomplishments**

Women and men in the family planning clinics were screened for weight, height and BMI calculations at their annual appointments and as needed for follow up visits. Written information in English and Spanish is offered, along with individual counseling by the LHU Nurses and Clinicians. Family planning services were offered in 85 Local Health Units and one contracted site.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Policy and procedure has been introduced requiring that staff at the 92 DOH Family Planning Clinics provide clients at their annual exam a BMI and counseling.		X		
2. All DOH clinics have been provided a scale with an attached device for measuring height, along with a BMI chart to hang on the wall and literature on weight control and obesity.		X		
3. Education, reminders and monitoring on providing BMI and counseling are being provided to DOH staff.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

ADH Local health units continue to provide BMI assessments, nutritional education/counseling and emphasis on healthy lifestyles.

Preconception identification of BMI >30 provide the opportunity to educate the client on this prenatal risk.

ADH and DHS employees are encouraged to participate in a worksite wellness program called the Arkansas Healthy Employees Lifestyle (AHELP) and an annual friendly competition with a health-related industry, the Blue and You Fitness Challenge. The goal is to encourage state employees to live a healthy lifestyle by focusing on proper nutrition, exercise, and smoking cessation and to for healthy state employees to be an example to other Arkansans. The Healthy Arkansas website provides strategies to assist participants to be successful. In November 2007 Governor Mike Beebe announced that HELP was expanding to all state agencies. Though not mandatory, the Arkansas Department of Health would assist interested agencies to establish a HELP.

#### **c. Plan for the Coming Year**

Efforts to identify resources for referral for nutritional counseling and planning are being made. Access to nutritionists is limited. However discussion of enhancing the availability of community-based resources to provide information, education and guidance to people desiring to eat right and be more active is taking place at many levels of the Department of Health, and in many locations in each community. ADH will continue to look for ways to develop effective partnerships to stimulate plans and activities to reduce obesity and the risk it brings.

Emphasis on staff providing the BMI and counseling will continue, as well as monitoring.

ADH will continue to market HELP to other state agencies. Even though the expansion has been slow, the opportunity to provide HELP to all state agencies is a tremendous step towards reaching many thousands of Arkansans in the workplace.

## **E. Health Status Indicators**

*/2009/ The Health Status Indicators that the MCH Program follows include several groups:*

*(a) measures low birthweight rates for all and for singleton births, very low birthweight rates for all*

*and singleton births, and other measures such as infant, neonatal and perinatal mortality rates.*

*(b) measures related to fatal and nonfatal unintentional injuries.*

*(c) two indicators of chlamydia rates, one among women 15-19 and the other among women 20-44.*

### **a. Perinatal indicators, and a discussion of c. Chlamydia indicators**

*Arkansas's low and very low birthweight rates have been increasing almost every year since 2001. ADH notes that the increasing trends are occurring both among all births and among singleton births, suggesting that artificial reproductive technology leading to more multiple births is not the only explanation for the phenomenon. That these increases should be happening during years when both the numbers of births, the birth fractions, and birth rates among teenagers have all been declining steadily argue against adolescent pregnancy as an explanation for the disturbing rise in birth weight rates. This year, attention has come to the fact that the increases in LBW rates now appear to be greater among the birth weight range 1500 - 2500 grams. That change is consistent with a rise in preterm births and birth rates for gestational ages 34-37 weeks. These findings suggest that questions be raised about inductions and c-sections being performed too early. ADH is investigating these questions.*

*In Arkansas, the research evaluation of the ANGELS Initiative has again confirmed this worsening of birth weight distribution, but has shown increases in infant survival in many low weight categories despite the increasing risks to survival from birth weight shifts. ANGELS evaluation shows preliminary information suggesting that for babies under 1000 grams, an increase in referrals to UAMS from communities more than 80 miles distant from Little Rock has occurred. Since UAMS gets dramatically better survival rates for these very tiny babies than community hospitals, the trend toward reduced neonatal death rates in this group is explained. Posters presented to national meetings indicate that not only are lives saved, but also hospital lengths of stay for the extremely low birth weight are reduced, and costs reduced as well.*

*One issue that should be looked at much more carefully is the correlation between infections of the genital tract and preterm birth. Chlamydia, as seen from the final group of indicators, is increasing among women of all ages, but especially among adolescent women. Some research shows correlations between chlamydia infections and low*

*birthweight, but the evidence base on identification and treatment of chlamydia infections in pregnancy and its impact of LBW or PTL is still rather slim. Discussion is going on in the Department of Health, with ADH's STI program partners about how providers might intervene to change the trend of increasing chlamydia infections among reproductive age women. Looking at Gonorrhea, the incidence of which is declining and has been much better under control, ADH is able to make visits to most sexual contacts of the infected patient to "epi-treat" that infection. The infrequency of Gonorrhea makes this possible. But ADH does not follow that pathway for Chlamydia because the prevalence of Chlamydia is so much higher and clearly exceeds the capacity of ADH's public health nurses and Disease Intervention Specialists to make all the necessary visits. It might be very helpful to have a pilot effort done somewhere in the US to see if Chlamydia can be brought under control from such a specially-funded effort.*

*Regarding group (b), the fatal and non-fatal unintentional injuries are also a subject of a great deal of interest in Arkansas. Among children 14 and younger, motor vehicle deaths are not declining. In fact, the data suggests a possible increase in 2006. Since these numbers are relatively small, it is unwise to conclude that the problem is coming under control, until data shows several years of lower values. This is especially true because the indicators regarding non-fatal injuries to children 14 and under show steady and relatively large increases in both numbers and rates in recent years.*

*Arkansas has been working most actively to address these injury and fatality data through concentrated public health efforts to enhance safety seat, booster seat, and seatbelt laws in the state. A campaign is under way involving partners such as the state Attorney General's Office, the ADH, the State Police, the National Highway Traffic Safety Agency and many community advocacy groups to enhance Arkansas state law so that police officers may stop vehicles for a primary offense having only to do with seatbelt violations. Additionally, the problem of all-terrain-vehicle injuries and deaths is receiving a lot of new emphasis. The College of Public Health and Arkansas Children's Hospital has published articles of the prevalence of this problem, and its extremely high frequency in certain rural counties in our state. A very active community intervention in Newton County (a very high sub-population of ATV users) has begun approaches to schools, parents, local coalitions, and news media including TV, newspapers, and billboards. This intervention is being evaluated, and has attracted some attention nationally in the form of a developing partnership with West Virginia to replicate the interventions in Newton County.*

*More generally, Arkansas's capacities to collect data, generate reports, post those data on the internet website, and link information from different data sets has taken some dramatic steps forward in the last 5 years. ADH has hired a new group of epidemiologists, each of whom has a specific program responsibility, but all of whom participate on a team to increase the overall use of data for strategic and local planning efforts. The State Center for Health Statistics now has data sets and staff that can and do respond quickly to many data requests from many sources. Programs have much better access to their data than ever before. The web postings available are to some degree interactive for visitors to the page. Within the agency the development of a software package called "Business Objects" puts program managers and professionals immediately in touch with administrative data such as unduplicated counts of patients, and categories of services, as well as health status information.*

*As time goes by and Hometown Health Initiative Coalitions become more active and begin to grapple with specific health problems of community interest, more requests are coming from them for statistical support. The number of school systems that have now conducted their own Youth Behavior Risk Surveys has increased quickly in the past 5 years, and much new local data is available for local planning.*

*With regard to evaluation, the College of Public Health has brought major new interests to*

***research evaluation at the community level. Community-based research is a recognized term, not only in the halls of the college, but in a number of involved counties, especially in the Mississippi Delta region of the state. Phillips County is especially actively involved in research around nutritional and physical activity enhancements that result from partnerships with local businesses, advocates, and health professionals. There are a number of other Delta Grants (EX.: Arkansas Delta Regional Developmental Networks) that are now exploring the impact of "community connectors" as well as coalitions of community planners and leaders. They are directly supported by faculty and research dollars through the COPH. Access to all the ADH Center for Health Statistics data, public health services, and survey information is envisioned and already to some degree used to support these efforts. //2009//***

## **F. Other Program Activities**

Other program activities relevant to women and children include Breast and Cervical Cancer Control, Diabetes Prevention and Control, Cardiovascular Health, and the Tobacco Prevention and Education Program. These programs are located in the Chronic Disease Branch, also within the Center for Health Advancement.

The purpose of the Breast and Cervical Cancer Control Program (BreastCare) is to reduce morbidity by increasing the rate of early detection of breast and cervical cancer through education, screening, diagnosis and treatment of women in Arkansas.

### **Target Population**

BreastCare continues to focus screening efforts on women 40 years old and older throughout Arkansas that are uninsured or underinsured and have rarely or never been screened for breast and cervical cancer and on women in special populations.

### **Description of Services**

-The BreastCare Program's goals and activities include the following:

·To provide education to the public about the importance of breast and cervical screening.

BreastCare is currently providing mini-grant funding to a total of 14 community and faith-based organizations for activities that promote outreach and educational efforts.

·To create statewide partnerships to promote collaboration and provide navigation through the medical system. BreastCare is collaborating with partners such as YWCA EncorePlus and The Witness Project to reduce barriers to screening services and to navigate patients through the system.

To increase enrollment in the BreastCare Program by increasing the availability of free screening and follow-up services to uninsured and underinsured women.

- Comprehensive Cancer Control Program is to provide a framework for action to reduce the burden of cancer in Arkansas.

### **Target Population**

The Comprehensive Cancer Control Program targets: 1) underserved residents of the state, 2) decision-makers and health policy-makers, 3) youth of Arkansas.

### **Description of Services**

The Comprehensive Cancer Control Program coordinates planning and implementation of a broad array of partner activities in the following areas:

·Public education and prevention

·Early detection, treatment and support

·Professional education and practice

·Evaluation

The purpose of the Diabetes Prevention and Control Program (DPCP) is to reduce the burden of diabetes and its complications in Arkansas.

#### Target Population

Persons at risk for diabetes statewide.

#### Description of Services

- Collects, analyzes, and distributes data on diabetes;
- Establishes and maintains a statewide diabetes coalition;
- Develops and promotes public education awareness campaigns;
- Creates and distributes educational materials for all diabetes populations;
- Develops outreach programs for minority populations;
- Partners with public and private organizations to increase the number of ADA recognized diabetes education programs in the state;
- Participates in a statewide diabetes collaborative based on the chronic care model;
- Provides community, organization project kits and assists in implementation of interventions related to diabetes such as the Lower Extremity Amputation Prevention program implemented through Hometown Health Coalitions.

The purpose of the CVH Program is to develop a state plan to reduce the burden of cardiovascular disease (CVD).

#### Target Population

All Arkansans.

#### Description of Services

The goals of the program are to:

- Improve cardiovascular health of all Americans
- Reduce disparities
- Delay onset of disease
- Postpone death
- Reduce disabling conditions

To achieve these goals, the CVH Program:

- Facilitates the CVH Program's Task Force in developing a state plan
- Developed a report on the Burden of CVD in Arkansas, "Mortality, Cost, Disparity, and Risk Factors;"
- Contracts for surveys to help define the burden of disease in Arkansas:
  - A work site survey
  - A chart review health site survey
  - A seven-county Delta survey
- Partners with the Arkansas Wellness Coalition -- a collaboration of public and private sector health organizations and networks to provide American Heart Association and CVH guidelines and tools to physicians within the State
- Collaborates with the Community Health Centers of Arkansas, Inc. (CHCs) to spread the Chronic Disease Collaborative Model for Cardiovascular and Diabetes within the CHC and other systems.

The purpose of the Tobacco Prevention and Education Program (TPEP) is:

- To reduce disease, disability and death related to tobacco by preventing the initiation of tobacco use among young people;
- Promote quitting among young people and adults;
- Eliminate exposure to second-hand smoke and identifying and eliminating the disparities related to tobacco use and its effects on population groups.

#### Target Population

All Arkansans with particular attention to preventing the initiation of tobacco use among youth and

promoting quitting among tobacco users.

#### Description of Services

Community Programs: Grants have been awarded to 49 communities to build coalitions with diverse partners; create tobacco-free environments; reduce youth access; decrease advertising and promotion of tobacco products and promote the use of cessation resources.

//2006// Other new activities that will impact on the MCH Programs relate to the development of a whole new Branch as part of the Center for Health Advancement. Called the LifeStage/HealthyArkansas Branch, this unit will be hiring staff in three population areas and three skill areas. The areas addressing broad populations, each as a group include Children in Schools, Adults in the Workplace, and the Elderly. The areas addressing skills include Physical Activity, Nutrition, and Tobacco Cessation. These new staff will be well trained public health leaders who will become knowledgeable each in his own area relative, not only to the science base in the area, but also the community based issues and activities.

//2008// Family Health is encouraging all Branches of the Center for Health Advancement to do some common strategic planning. All Branches have interests in activities regarding public awareness, social marketing, patient education and professional education. It is apparent that funds from all Branches could be coordinated to build capacity within the Center enhance operations of these kinds. With this in mind, and thinking forward to the next five-year MCH Block Grant cycle, it has been suggested that the Center for Health Advancement design a collaborative needs assessment for the health of women and children in Arkansas, following which coordinated approaches involving all Branches could be devised to be implemented in the MCH Block Grant Application submitted in 2009 for FFY 2010. //2008//

### **G. Technical Assistance**

The Arkansas Division of Health, Women's Health Work Unit, requests assistance for a prenatal services assessment. The assessment would include evaluations and recommendations for improvement in the clinical services, patient flow, also client and colleague satisfaction. An independent consultant firm would be utilized to provide this operational analysis and assessment. The chosen firm would provide recommendations to improve operational processes: thereby giving suggested means for measurable improvements in prenatal care services provided by our agency.

Assistance is requested on the best techniques to use in forming a MCH partnership among multiple agencies to increase the quantity and quality of public input and participation in issues around MCH. The UAMS College of Public Health through student preceptorships and integration projects would provide technical assistance.

//2007// The Family Health Branch requests assistance in identifying ways to address lead screenings in Arkansas. Our problem is a systems problem, i.e., linking WIC, private providers, Medicaid, and the appropriate laboratory. A CDC consultant could be utilized to help us address our lead screening needs. //2007//

//2008// The Title V CSHCN program requests technical assistance in the area of methods to hire more parents of CSHCN, whether by contract or sub-grant, including how to write the contract/sub-grant and methods of monitoring. The Title V CSHCN program does not have experience within the leadership in the area of contracts. //2008//

//2008// Given that Medicaid earnings for prenatal care have been level and not increasing, and that state agency budgets remain stretched to continue the basic programs, the Family Health Branch would like to consider implementing a fee for prenatal care. The fee would be discounted for families under 200% of poverty and no cost for those under 100% of poverty. It would be set up in a well published policy and local health unit patients would be informed. No patient would

be denied services based on ability to pay. Technical assistance with the process of determining the true cost of providing the services is desired.//2008//

//2008// As the Family Health Branch looks forward to initiating a new five year plan to be implemented starting in July 2009, advance work must be done to conduct the required needs assessment, and develop a subsequent implementation plan. We envision a stage in which stakeholders will be brought together, first within the ADH, and subsequently from among our external planning partners, to establish priorities. We would like these stakeholder discussions, once priorities are being advanced for selection, to be informed by the latest scientific evidence regarding "best practice" interventions that might be employed. A technical assistance effort devoted both to guiding effective stakeholder input, and to selecting best practice interventions would be very helpful. These could take place either in FY 2008 or 2009, or both. //2008//

## **V. Budget Narrative**

### **A. Expenditures**

/2006/ Total Expenditures for the FY2004 Federal-State MCH Partnership were \$25,262,986 a substantial decline from the amount budgeted, \$33,831,514, for FY2004, or expended the previous year \$31,078,443. Expenditures at ADH dropped as reductions in direct services occurred. This was particularly apparent with MCH Block funds, as provision of maternity care was reduced. As direct services declined, Medicaid revenues declined proportionally. These declines resulted in the reduction of 123 positions throughout ADH, the actual lay-off of 38 employees, and reassignment of 11.

The state match contribution of \$18,362,351 more than met the maintenance of effort requirement of \$5,797,136. Much of the ADH's state contribution has been documented through time-allocation. In July 2001, the Arkansas Administrative Statewide Information System, an integrated accounting, human resources, and materials management System provided a modern, automated accrual accounting system across all state agencies. The system was implemented without a cost-allocation system. Consequently, state effort from time allocation in this application is based on 2001 figures, which have been adjusted for changes in clinic activity and increases in salary. This situation should be rectified by July 2005 as a cost allocation system compatible with AASIS is currently under development. A new e-mail-based random moment time allocation system was implemented July 1, 2005. Data from this system will be available for FFY 2006 to document the state effort provided.

Expenditures of program income of \$13,089,886 were less than the \$17,486,955 budgeted. This decrease included declines in ADH clinical activity and income from case management performed by CMS.

ADH has made a concerted effort to redefine budget to distinguish direct services from enabling services and population-based services. Also, numbers are affected by caseload declines across programs in FY 2003. Movement of state match away from well-child clinics to immunization clinics moved nearly \$3 million in expenditures from direct services to population-based services.

ADH identified expenditures for health education and other enabling services that had previously been counted as direct services. This included surveying staff regarding the amount of time expended in family planning and maternity offices visits that was directed toward health education and other enabling services, as opposed to the direct provision of health care services. This moved about one-third of staff time for family planning and about forty percent of staff time for maternity to enabling.

The CSHCN budget for FFY 2004 reflects a difference of \$4.3 million dollars between the 2004 budgeted and expenditure amounts. Budgeted program income for FFY 2004 was \$2.5 million in case management revenue from Medicaid. Actual income received for case management billing during that time period was \$1.4 million. Total expenditures in FFY 2004 for Children's Services was \$4.07 million, which was a decrease of \$3.28 million from expenditures in FFY 2003. This decrease is attributed to a change in eligibility criteria established in earlier years. Financial eligibility criteria decreased to 185% of Federal Poverty Level and age eligibility criteria was changed from age 21 years to age 18 years. These changes coupled with an ongoing problem with issuing payments via electronic means resulted in the decreased spending. Decreased program income plus decreased spending equals the variance from the planned budget.

//2007// Total Expenditures for the FY 2005 Federal-State MCH Partnerships were \$24,442,925, a substantial decline from the amount budgeted, \$30,421,208, for FY 2005, or expended the previous year - \$25,262,986. Expenditures at the Department of Health and Human Services-Division of Health dropped as reductions in direct services occurred. This was particularly

apparent with MCH Block Funds, as provision of maternity care was reduced. As direct services declined, Medicaid revenues declined proportionally.

The total state match contribution of \$21,211,514, more than met the Maintenance of Effort requirement of \$5,797,137. The Division of Health's contribution is \$17,225,686. The Department of Health and Human Services is working toward incorporation of Division of Health operations into the agency's cost allocation plan. An automated random moment time study process for county nurses and clerical staff is currently in development, which will be used to provide documentation and support in a cost allocation plan amendment. The amendment will be submitted to the Dallas Regional Office of Health and Human Services, Division of Cost Allocation asking for an effective forward activity date of July 1, 2007 as part of a Division of Health package. This date coincides with the finalization of single agency business area financial reporting. Approval documentation will be provided to USDA following DCA approval.

Expenditures of program income of \$12,264,962 were less than the \$15,264,743 budgeted. This decrease included declines in Division of Health's clinical activity. //2007//

//2008// Total Expenditures for FY 2006 Federal-State title V Block Grant Partnership totaled \$32,493,293 an increase from last year and much closer to the amount budgeted of \$30,806,594. Expenditures at the Department of Health and Human Services rose as costs rose. This was especially evident in the cost of salaries, as a new salary structure was introduced to make nurse salaries more competitive with the private sector. Besides the additional cost increase per nurse, the Division was successful in decreasing the number of unfilled nursing positions, due to the increase in pay. This also increased the amount of money spent on salaries.

The total state match contribution of \$21,286,889 more than met the Maintenance of Effort requirement of \$5,797,136.

For state fiscal year 2007-08, the Arkansas Department of Health is under an approved Indirect Cost Rate. For the preceeding two state fiscal years, as a division of the Arkansas Department of Health and Human Services (DHHS), a cost allocation plan was developed and submitted to HHS Division of Cost Allocation in Dallas, but not yet approved, under 2 CFR Part 225 Appendix D Public Assistance Cost Allocation Plans. As a stand-alone public health agency, ADH cost allocation requirements align with 2 CFR Part 225 Appendix E State and Local Indirect Cost Rate Proposals. We are working to develop a new indirect cost rate based on direct salaries to submit to HHS Division of Cost Allocation in Dallas. //2008//

***//2009/ The total expenditures for fy 2007 Federal-State Title V Block Grant Partnership totaled \$33366269, an increase from last year. Expenditures rose due to salery increases, supply cost increases, a new salary grid for nurses and consequently a decrease in unfilled positions at the Arkansas Department of Health. The family planning program and maternity program did see a reduction in patients resulting in some decrease in expeditures.***

***The Department of Human Services' Children with Special Health Care Needs (CSHCN) program used Title V carryover funds from FFY 06 (Oct 1 2006 through Sept 2007) during the FFY 07 for payment of medical expenses for non-Medicaid clients, purchase of items not covered by Medicaid that ease the physical burden of caring for CSHCN in the home and for continuation of the Title V Family Support/ Respit program.***

***For state fiscal year 2007-08, the Arkansas Department of Health is under an approved Indirect Cost Rate. For the preceeding two state fiscal years, as a division of the Arkansas Department of Health and Human Services (DHHS), a cost allocation plan was developed and submitted to HHS Division of Cost Allocation in Dallas, but not yet approved, under 2 CFR Part 225 Appendix D Public Assistance Cost Allocation Plans. As a stand-alone public health agency, ADH cost allocation requirements align with 2 CFR Part 225***

***Appendix E State and Local Indirect Cost Rate Proposals. ADH is working to develop a new indirect cost rate based on direct salaries to submit to HHS Division of Cost Allocation in Dallas. ADH presently conducts a 100% survey of employees regarding how much time they are spending on activities that can be tied to specific funding streams. //2009//.***

## **B. Budget**

After the budget shortfall ADH faced in state fiscal year 2005, the agency recovered somewhat in clinical efforts and income. Both maternity and immunization performance improved markedly and family planning stabilized. This was after the Department had experienced a 30 percent decline in clinical visits from 2001 to 2004. Overall clinical activity improved by 10.4% in 2004.

The projected Title V appropriation for Arkansas was estimated at \$7,483,501. Preventive and Primary Care for Children is budgeted at \$4,066,144 or 54.3% percent of the total. The amount projected for CSHCN (CMS) is \$2,345,187, which is 31.34 percent of the total. Title V administrative costs are estimated at \$428,392, 5.7% of the total allocation. The amount of total State funds budgeted is \$7,003,381. The total state match is 22,251,115. Each of these budgeted items satisfies the legislative requirements. Total carryover projected from previous years is \$1,071,978. The large amount of carry-over is the result of reductions in ADH clinical services and CMS case management services.

The MCH budget reflects expenditures budgeted on program income have stabilized since last year. The State MCH Budget Grand Total has increased to \$111,266,765. Much of this increase was from federal funds, particularly, WIC.

\$13,231,720 of the FY2006 ADH share of the Federal State Title V Block Grant Partnership Total will be expended for direct health care services. This reduction reflects both the actual declines in the provision of services and re-computation of the expenditure by type of service taking into account that immunization activity is counted as population based services, and re-categorizing some activities formerly counted as direct services more appropriately as enabling services. Also, much of the state match counted in previous years reflected effort in child health clinics and school health. This effort has been replaced by child immunization activity. The pyramid reflects that more MCH grant funds are now directed to the Hometown Health effort and building infrastructure in local communities.

The Title V Block Grant for CMS is projected to be \$2,605,755 plus a carryover of \$198,958 has been estimated. The state funds to CMS totals \$2,114,531.

Non-Federal Funding -- CMS receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CMS program. This funding is estimated at \$1,500,000 in FFY 2005. These funds are categorized as program income. Policy Development and Program Development and Management are included in the administration of Title V. Quality Assurance & Standards Development and Community Assessment are included in CSHCN Care Coordination.

CMS Administrative costs are budgeted at \$2260,568 Title V and \$97,976 state funds. The budget by types of service is estimated along with the breakdown of administrative costs for each of the four types of services.

//2007// The projected Title V appropriation for Arkansas was estimated at \$7,191,246. Preventive and Primary Care for Children is budgeted at \$3,672,379 or 51.0674 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is \$2,253,593, which is 31.338 of the total. The Title V administrative costs are estimated at \$476,589, 6.6273 percent of the total allocation. The amount of total State funds budgeted is \$7,790,017. The total state match is \$21,211,514. Each of these budgeted items satisfies the

legislative requirements. Total carry forward projected from the previous year is \$854,898 (\$851,517-CMS; \$3,381-DOH). CMS' increase in unobligated fund balance correlates to provider billings for direct medical services as well as normal variations between budget forecast and actual operations. The federal Title V funding carryforward will be expended in FFY 07. The state funds to CMS total \$2,516,925 including \$162,978 allocated to administrative costs. The remainder of the required state match is derived from expenditures on direct services and insurance collections. Without these insurance collections, CMS would have to pay more out of state funds to the hospital for direct medical services.

The MCH budget reflects a decrease in expenditures budgeted on program income since last year. The State MCH Budget Grant Total has decreased to \$34,183,136. Much of this decrease is from Federal funds, particularly WIC, Injury Prevention, and Oral Health. These programs are no longer under the control of Richard Nugent, M.D., the person responsible for the administration of the Title V program.

\$17,455,117 of the FY 2007 ADH share of the Federal-State Title V Block Grant Partnership Total will be expended for direct health care services. //2007//

//2007// Non-Federal Funding - CMS receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CMS program. This funding is estimated at \$1,468,903 in FYY 2007. These funds are categorized as program income. Policy Development and program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community are included in CSHCN Care Coordination.

Administrative costs are budgeted at \$250,299 Title V and \$162,978 state funds.

The budget by types of service is estimated along with the breakdown of administrative costs for each of the four types of services. //2007//

//2008// The projected Title V appropriation for Arkansas was again estimated at \$7,191,246. Preventive and Primary Care for Children is budgeted at \$4,266,223 or 59.33 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is \$2,445,023, which is 34 percent of the total. The Title V administrative costs are estimated at \$480,000, 6.67 percent of the total allocation. The amount of total State funds budgeted is \$8,079,781. The total state match is \$21,286,889. Each of these budgeted items satisfies the legislative requirements.

The state funds to CSHCN totaled \$2,526,242 including \$166,922 allocated to administrative costs. The remainder of the required state match is derived from expenditures on direct services and insurance collections. without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. This funding is estimated at \$1,624,854 in FFY 2008.

Policy Development and Program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community Assessment are included in the program partners making up the Title V Block Grant.

\$22,266,507 of the FY 2006 ADH share of the Federal-State Title V Block Grant Partnership Total was expended for direct health care services. //2008//

***//2009/ The projected Title V appropriation for Arkansas was lowered to \$7,066,705 to reflect reductions in funding during the present grant period. Preventive and Primary Care for Children is budgeted at \$4,134,729 or 59.51 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is \$2,460,627, which is 34.82 percent***

***of the total. The Title V administrative costs are estimated at \$471,349, 6.67 percent of the total allocation. The amount of total State funds budgeted is \$3,149,026. The total state match is \$16,201,750. Each of these budgeted items satisfies the legislative requirements.***

***The state funds projected to CSHCN total \$1,729,279 including \$126,537 allocated to administrative costs. The remainder of the required state match in CSHCN is derived from expenditures on direct services and insurance collections. Without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. This funding is estimated at \$1,551,299 in FFY 2009.***

***Policy Development and Program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community Assessment are included in the program partners making up the Title V Bock Grant.***  
***//2009//***

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.